ASSESSING FITNESS TO STAND TRIAL: CHARACTERISTICS OF FITNESS REMANDS AND A COMPARISON OF INSTITUTION-BASED EVALUATIONS AND THE FITNESS INTERVIEW TEST - REVISED

by

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Assessing Fitness to Stand Trial: Characteristics of Fitness

Remands and a Comparison of Institution-Based Evaluations and

the Fitness Interview Test - Revised

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Abstract

Two studies that examined issues related to the assessment of fitness to stand trial were conducted. File information was collected and analyzed for 180 males remanded for inpatient fitness evaluations between October, 1994 and July, 1995. Study 1 examined the characteristics of the entire sample of remands and compared defendants deemed fit to stand trial as a result of the institution-based evaluation with those considered unfit to stand trial. The results confirmed previous research that indicated that remanded defendants are more likely to be single, unemployed, X living alone, and to have no fixed address, and that unfit defendants are significantly more likely to have never been married. As well, the results indicated that those individuals who were found unfit to stand trial were significantly less likely to have been given a diagnosis of a drug or alcohol use disorder and were four times more likely to have been given a diagnosis of a psychotic disorder. Another important result of Study 1 indicated that while the new Code called for a 5-day evaluation period, it appears that this is rarely accomplished and, in fact, the average length of time for an assessment of fitness is 23 days. Study 2 compared decisions about fitness to stand trial based on the Fitness Interview Test - Revised (FIT-R) and institution-based evaluations for a sub-sample of 57 males remanded for inpatient fitness assessments during the same time period as Study 1. The results indicated that the FIT-R demonstrates excellent utility as a screening instrument. The FIT-R shows perfect sensitivity and negative predictive power which indicates that it can reliably screen out those individuals who are clearly fit to

stand trial before they are remanded to an inpatient facility for a fitness assessment. Specifically, in this study 82% of the individuals would have been screened out before being remanded for a lengthy inpatient evaluation of fitness. The implications of these results for evaluating fitness to stand trial are discussed.

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INTRODUCTION

Dating back to English common law, fitness to stand trial[1] has been a generally accepted legal principle. That is, an individual charged with a criminal offence must be able to understand the nature of the proceedings and assist counsel to participate in his or her own defence in order to have a fair trial (see R. v. Pritchard, 1836; The Queen. v. Berry, 1876). It was thought that the presence of a mental disorder might pose a serious impediment to an individual's understanding of the proceedings and ability to assist counsel. If an individual is suffering from a mental disorder at the time of the trial it is still important that he or she is able to defend him or herself and, if this is not possible, the individual is said to be unfit to stand trial. The judicial proceedings are then suspended until the individual becomes fit to stand trial. Until recently, unfit defendants were typically committed to inpatient facilities for an indeterminate period until they were fit; at which time they were returned to court.

Prior to 1992 there was no set definition that was used to determine whether or not a defendant was unfit to stand trial. The criteria that were used were taken from case law. Specifically, the case of R. v. Pritchard has often been cited as the "'classic test' for the determination of fitness to stand trial" (Lindsay, 1977, p. 306). In Pritchard, the judge ruled that there were three

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[1] Fitness to stand trial is the terminology that is used in Canada. Other countries use equivalent terms such as competency to stand trial and capacity for trial.

issues that must be determined in order to assess whether or not a defendant was fit to stand his or her trial.

> First, whether the prisoner is mute of malice or not; secondly, whether he can plead to the indictment or not; thirdly, whether he is of sufficient intellect to comprehend the course of the proceedings on the trial, so as to make a proper defence -- to know that he might challenge any of you to whom he may object -- and to comprehend the details of the evidence, which in a case of this nature must constitute a minute investigation. (p. 304)

Lindsay (1977) reviewed Canadian case law and concluded that there are three questions which follow from the criteria set out in R. v. Pritchard that are usually asked in order to determine an individual's fitness. First, "does the accused understand the nature and object of the proceedings? (i.e., does he understand that this is a criminal trial[2]; does he understand what on oath is; does he know what the offence is etc.?)" (p. 306). Second, "does the accused understand what his relationship is to the proceedings? (i.e., does he understand that he and not somebody else is on trial; that he has the right to rebut the charges; that he may be incarcerated if he is found guilty etc.?)" (p. 307). Third, "is the accused able to assist in his defence? (i.e., can he communicate with his counsel; is he capable of giving evidence himself, if necessary; can he make strategic decisions with respect to the conduct of his defence etc.?)" (p. 307). Lindsay

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[2] In the past authors have, although incorrect, used "he" to refer to defendants when talking about fitness to stand trial when they were meaning to refer to both sexes.

(1977) concluded that these three questions identify important areas to assess when determining an individual's fitness to stand trial even though "the concept of unfitness does not embrace any single standard" and its meaning varies according to "the type of mental defect, the nature of the proceedings and the way in which defence counsel relates to his client and conducts his defence" (p. 307) .

Revised Criminal Code

In 1992, the Criminal Code of Canada (Code) was amended. Bill C-30 made many changes to the legal procedures related to the determination of fitness to stand trial as well as criminal responsibility. Explicit guidelines were laid out in Section 2 which included a definition as well as criteria for the determination of fitness to stand trial. Unfit to stand trial is a legal term that means "unable on account of mental disorder to conduct a defence at any stage of the proceedings before a verdict is rendered or to instruct counsel to do so, and, in particular, unable on account of mental disorder to (a) understand the nature or object of the proceedings (b) understand the possible consequences of the proceedings, or (c) communicate with counsel" (C.C.C., S.2, 1992).

The revised Code also set out the guidelines regarding assessment orders as well as the length of time for assessments and extensions. Section 672.11 indicates that the court may order an assessment of an accused's mental condition if it believes that such evidence is necessary to determine

(a) whether the accused is unfit to stand trial;

(b) whether the accused was, at the time of the commission of the alleged offence, suffering from a mental disorder so as to be exempt from criminal responsibility by virtue of subsection 16(1);

(c) whether the balance of the mind of the accused was disturbed at the time of the commission of the alleged offence, where the accused is a female person charged with an offence arising out of the death of her newly-born child;

(d) the appropriate disposition to be made, where a verdict of not criminally responsible on account of mental disorder or unfit to stand trial has been rendered in respect of the accused; or

(e) whether an order should be made under subsection 736.11(1) to detain the accused in a treatment facility, where the accused has been convicted of the offence.

The Code also states that the court may order an assessment at any stage of the proceedings upon its own application or that of either the defence or the prosecution. With regard to the length of time for which an assessment can be ordered, it is stated in Section 672.14 that

(1) An assessment order shall not be in force for more than thirty days.

(2) No assessment order to determine whether the accused is unfit to stand trial shall be in force for more than five days, excluding holidays

and the time required for the accused to travel to and from the place where the assessment is to be made, unless the accused and the prosecutor agree to a longer period not exceeding thirty days.

(3) Notwithstanding subsections (1) and (2), a court may make an assessment order that remains in force for sixty days where the court is satisfied that compelling circumstances exist that warrant it.

The Code also makes provisions for extensions of the assessment order if it is necessary to complete the assessment of the individual's mental condition. The extensions are not to exceed 30 days in duration and the entire length of the remand including the extensions cannot exceed 60 days (S. 672.15). There is also a section of the Code that deals with the issue of treatment during assessment orders which states that "no assessment order may direct that psychiatric or any other treatment of the accused be carried out, or direct the accused to submit to such treatment" (S. 672.19).

The Code indicates that if an individual is found unfit to stand trial, the proceedings are to be set aside until the accused becomes fit to stand trial. As well, an inquiry is to be held every two years until the accused is either acquitted or tried to determine whether or not there is sufficient evidence to put the accused on trial (i.e., prima facie case). If it is determined that there is not enough evidence to put the accused on trial then the accused is to be acquitted.

The Assessment of Fitness

Traditionally, the courts have relied on mental health professionals, both psychiatrists as well as psychologists (although in Canada it is the psychiatrist who must write the report to court), to assess fitness to stand trial. For these assessments to be conducted in a uniform manner throughout the country, it is important to have consistent criteria for evaluating how the presence of a mental disorder affects an accused with regard to these three legal criteria. It is quite common that an individual with a mental disorder may still be found fit to stand trial (Golding, Roesch, & Schreiber, 1984). Roesch, Eaves, Sollner, Normandin, and Glackman (1981) found that while nearly all defendants who had been found unfit to stand trial had some form of psychosis, almost one-third of those found fit to stand trial were also considered to be psychotic. Presence of a mental disorder is obviously an important factor in assessing fitness, but mental disorder by itself is not sufficient to determine that a defendant is unfit (Roesch & Golding, 1980). Rather, it must also be shown that the mental disorder affects the accused's performance on one or more of the three legal criteria. Since 1992, there have also been finer distinctions made with regard to these three criteria. In the case of R. v. Taylor (1992) it was decided that the "test to be applied in determining the accused's ability to communicate with counsel is one of limited cognitive capacity" (p. 553). This means that it is not necessary that the accused be able to act in his or her own best interests, but rather must only be able to recount the necessary facts pertaining to the offence to counsel so

that counsel will then be able to present a proper defence. The appellate judge decided that the "'limited cognitive capacity' test strikes an effective balance between the objective of the fitness rules and the constitutional right of the accused to choose his own defence and to have a fair trial within a reasonable time" (p. 567). This case serves to narrow the criteria used to assess fitness to stand trial.

There has been an increasing amount of research conducted on the concept of fitness to stand trial since the 1960s (Nicholson & Kugler, 1991). One method that has been used in prior research on fitness to stand trial has been to examine the characteristics that distinguish defendants found to be fit with those found to be unfit to stand trial. Roesch et al. (1981), in a study of fitness remands conducted in British Columbia, found that referred defendants generally were largely "unemployed, single, and living alone" and that the majority had histories of "psychiatric problems and hospitalization" (p. 154). Specifically, unfit defendants were more likely than fit defendants to be either transient or living in a hotel at the time of arrest, and to be single. In a North Carolina study, Roesch (1979) examined the differences between those individuals found fit and those deemed unfit. The unfit defendants were significantly more likely to have a psychiatric diagnosis of psychosis or mental retardation than were the fit defendants. It is not possible, of course, to establish a causal relationship since it is not clear whether the psychiatric diagnoses may have influenced the determination of fitness, or whether the

determination of fitness influenced the psychiatric diagnoses. Hart and Hare (1992) examined the power of demographic, clinical, and criminal variables in predicting fitness and determined that clinical variables, especially the diagnosis of psychotic disorders, were the most effective predictors of fitness. It is important to note that these studies were carried out before the introduction of Bill C-30 and that there may be differences in the number and type of defendants who are now referred for fitness evaluations.

As indicated earlier, before the enactment of Bill C-30 in February, 1992, a person could be remanded to custody for an assessment of fitness for a period of 30 days. Is this period of time necessary or sufficient for determining fitness? Roesch (1979) compared the decisions about fitness that were made using a brief interview with those made after a period of detention in a psychiatric hospital. He found that the additional information obtained during hospitalization had little influence on the judgments about fitness. Based on his research Roesch suggested that such lengthy periods of hospitalization, which were not only costly but which also deprived these individuals of their liberty, were unnecessary for the majority of decisions.

Prior research on fitness to stand trial has identified a number of important areas that need to be considered in further detail (Roesch & Golding, 1980). One of these areas is the amount of resources, such as time and money, allocated to the determination of fitness. Many researchers, including Roesch and Golding (1980) and Menzies, Webster, Butler, and Turner (1980) have

found that only a small proportion of those individuals who are remanded for fitness assessments are actually found unfit to stand trial. The numbers range anywhere from 2% to 38% of those remanded for fitness assessments that are actually found unfit (cited in Roesch, 1978b). Several reasons have been cited for this. First, because the jails are becoming increasingly overwhelmed with a growing number of mentally ill individuals, fitness remands are sometimes used as a "backdoor" way of steering these individuals away from overcrowded penal institutions and into mental health facilities (Roesch & Golding, 1985). Second, these individuals are sometimes remanded for fitness evaluations as a way of getting them into a mental health facility for treatment when they will not voluntarily commit themselves to a mental health facility for treatment or outpatient treatment is unavailable (Grisso, 1986). Third, the fitness assessment may be used as a legal maneuver that allows prosecutors more time to prepare their case and defence attorneys the opportunity to gain information that could be used to determine the feasibility of a later insanity plea (Roesch & Golding, 1980). It, therefore, makes sense to screen out those individuals for whom there is no question as to their fitness to stand trial. Roesch (1978a) concluded that a brief, immediate screening interview could be used to evaluate fitness to stand trial and that this method resulted in a reduced cost and an increase in the protection of individual rights over the method of having an individual remanded to a psychiatric institution for lengthier evaluations. He reported a high agreement between judgments of fitness based upon a brief screening interview

and lengthy institutional evaluations of fitness. Brief screening instruments would save resources such as time and money as the screening procedure could be done within a couple of hours and would not require that the individual be placed in a costly psychiatric institution.

Measures of Fitness

Many instruments have since been developed to assess fitness to stand trial as well as other types of competencies. The Competency Screening Test (CST; Lipsitt, Lelos, & McGarry, 1971) was developed as a screening instrument to assess competency in pretrial defendants. The Interdisciplinary Fitness Interview (IFI; Golding, Roesch, & Schreiber, 1984) was designed to assess both the legal as well as psychological aspects of competency. The Competency Assessment Instrument (CAI; Laboratory of Community Psychiatry, 1974) was developed by McGarry and his associates at the Harvard Laboratory of Community Psychiatry for the assessment of fitness in the United States. The Fitness Interview Test (FIT; Roesch, Webster, & Eaves, 1984) was adapted from the CAI for use in Canada for this same purpose.

The FIT is a 28-item structured interview that is used to assess legal understanding and psychiatric impairment. Each of the items are rated on a 6-point scale measuring the degree of incapacity on that item. MacDonald, Nussbaum, and Bagby (1991) have shown the FIT has demonstrated excellent inter-rater reliability and is able to distinguish between fit, unfit, and questionable defendants. MacDonald et al. (1991) have also pointed out a number of

criticisms of the FIT. First, they note that many of the items are correlated highly with the overall scale and therefore, there is little discrimination between many of the items. As a result, the FIT may not be able to assess the various dimensions of fitness. Second, the scoring criteria have also been criticized as being too susceptible to bias wherein one of the items may taint the interviewer's view of the other items. These researchers have suggested defining the scoring in very concrete terms and locating the scale next to each item. Finally, these researchers have questioned the relevancy of the FIT to the Criminal Code of Canada as this instrument was adapted from the CAI and the American standards for fitness. The legal section of the FIT is comprised of questions that try to tap the three standards of fitness that were identified by Lindsay (1977) after his review of Canadian case law. The FIT has been criticized for its legal section being reducible to only two factors (Bagby, Nicholson, Rogers, & Nussbaum, 1992). As well, these researchers found that these two factors were not stable over time and therefore state that the legal component of the FIT may be unidimensional and unable to distinguish between the various dimensions of fitness. This instrument is currently being revised under a SSHRC grant to Professor Roesch. This revised version, the Fitness Interview Test - Revised (FIT-R; Roesch, Webster, & Eaves, 1994), has made changes that take these criticisms into consideration. The FIT-R no longer assesses the psychiatric abilities of the individual and instead, focuses on the legal abilities of the individual. The scoring system has been changed to a 4-point scale, with a

score of "0" meaning definite or serious impairment, a "1" meaning possible or mild impairment, a "2" meaning no impairment, and a "?" meaning that the interviewer does not have enough information to make the decision on that item. As well, the items on the FIT-R were developed to parallel the standards for fitness that were established in section 2 of the 1992 revision of the Criminal Code of Canada. It is this revised version of the FIT that will be used in Study 2.

The Present Research

Two studies were conducted to examine the issues discussed above. Study 1 explores the demographic, mental health, and criminological characteristics that might distinguish groups of defendants found fit to stand trial and those found unfit to stand trial as a result of inpatient evaluation in a psychiatric facility in British Columbia. As well, the entire referred group is examined to determine if the changes in the law have affected the make-up of the population referred by the courts for evaluations of fitness.

Study 2 compares the results of decisions about fitness to stand trial based on the Fitness Interview Test-Revised (FIT-R) and the Structured Clinical Interview for DSM-III-R (SCID) with decisions based on fitness assessments made at the Forensic Psychiatric Institute in Port Coquitlam, British Columbia. This was done to determine how well the FIT-R, using a 30-minute structured interview, and the SCID predict the decision made by forensic evaluators following a 5-day assessment at the forensic facility, and then to compare how these assessments of fitness relate to the ultimate decision of fitness as made

by the courts. The results of this study will provide information on the predictive validity of the FIT-R.

Often, when one is trying to validate a screening instrument, there may be discrepancies between the results obtained by the screening instrument and those obtained by the usual method of evaluation. These discrepancies may occur because of a problem with the screening device or because of differences in the individual who is being evaluated over time. If it turns out that there is a discrepancy between the decision about fitness made by the FIT-R and the decision made by the institutional evaluation one might be tempted to ask which decision is correct. In fact, they may both be correct. It is possible that, at the time that the FIT-R is administered, the defendant may be under the influence of drugs and/or alcohol, or be in such an emotional state that it is not possible to assess fitness at that time and the decision will be that the individual's fitness is questionable and a remand will be ordered to allow a more thorough investigation of fitness. This means that by the time these remanded individuals are assessed at the institution, they may no longer be under the influence and may be in a more rational state of mind, and therefore they may be found fit to stand trial. It is possible, then, for an individual to be considered to be unfit to stand trial at the time of arrest but then to be found fit to stand trial by the time they have been remanded to the psychiatric institution.

For the purposes of Study 2, the FIT-R was administered to individuals who had been remanded to the Forensic Psychiatric Institute. It is expected that

there should be a high rate of agreement between decisions of fitness made by the FIT-R and decisions made by the institution as the FIT-R is not being administered to these individuals immediately after arrest. It is also expected that there will be a high rate of agreement between the decision of fitness made as the result of the institutional evaluation and the ultimate decision of fitness as made by the court. This is because the court often takes into account the results of the institutional evaluation and rarely disagrees with this decision (Roesch & Golding, 1980). If the results indicate that the FIT-R predicts the court outcome, then it may not be necessary to have all individuals remanded for fitness assessments for up to a 5-day period and instead, the FIT-R could be used as a screening device. This would serve to eliminate those individuals who are clearly fit from being unnecessarily sent to an inpatient facility. Only those individuals who were considered to be unfit or to have questionable fitness by using the FIT-R would be remanded for further evaluation. If, however, the FIT-R does not reliably or validly predict this outcome, then it will be necessary to determine what factors the courts find to be of greatest significance and to try and work these into the FIT-R to improve its predictive qualities. As the FIT-R is a screening instrument, we would expect that the proportion of defendants found unfit to stand trial, using the decision of the FIT-R and the SCID, will be greater than those actually found unfit to stand trial using the institutional evaluation decision. If we consider the referral question to be "Is this defendant unfit to stand trial?" then deciding that a defendant is unfit when he or she is later found

to be fit to stand trial is a false positive error. As there are only two types of errors that can be made, the other is to decide someone to be fit when he or she is actually unfit. This error is a false negative. As the FIT-R will eventually be used as a screening device wherein those found unfit will then be referred for an evaluation in a psychiatric institution, it is desirable to minimize the number of false negative errors since this would inadvertently and inappropriately allow judicial process to continue for these individuals. False positive errors, on the other hand, do not have consequences that are as serious for the individual since he or she would only be referred for additional evaluation.

STUDY 1: CHARACTERISTICS OF FITNESS REMANDS

Method

Participants

The participants were 180 males who had been remanded to the Forensic Psychiatric Institute (FPI) in Port Coquitlam, BC for evaluations of fitness between October 11, 1994 and July 11, 1995. As illustrated in Table 1, most (60.6%) were single, White (69.3%), and unemployed (71.1%) at the time of admission to FPI. The average age at the time of admission was 35.21 (SD = 12.05) years. According to the files, 86.1% of the remands had previous contact with mental health professionals and 66.7% had previously been hospitalized for psychiatric problems. Also from the files, it was determined that 75% of the remands had previous criminal histories, 45.6% had previously been in prison, and 74.4% were currently remanded to FPI charged with offences against persons.

Procedure

File Information and Data Coding. File information was coded for every individual and included the determination of fitness made at FPI that was submitted in the psychiatrist's report to court, the diagnoses given at FPI, demographic variables, current charge(s), the presence of previous charges, and other psychiatric information. The coding form for the variables that were coded from each file is listed in Appendix A. No names were associated with the file information that was coded.

The charges for which the individual was currently remanded were re-coded into three categories. The first category was called "Violent" and consisted of those crimes that were committed against persons. Charges such as murder, threatening, possession of a weapon, assault, and sexual charges were included in this category. The second category was called "Property" and

consisted of those crimes that were committed against property. Charges such as mischief, break and enter, theft, and possession of stolen property were included in this category. The final category was called "Miscellaneous" and included all those other offences that were not committed against persons or property. Included in this category were crimes such as failure to appear, breach of probation order, and causing a disturbance. Also included in this category were those crimes that involved drugs or alcohol such as trafficking or drunk driving. The base rate of these types of crimes was so low in this sample that it was included in with the "Miscellaneous" category. Appendix B lists the charges for each individual and the respective categorization of those charges.

The diagnoses given to each individual by the psychiatrists at FPI were also re-coded into five categories. The first category was called "Psychotic" and included those diagnoses that were psychotic disorders or that contained psychotic symptomatology. Diagnoses such as Schizophrenia, Bipolar Manic Disorder, and Psychotic Disorder Not Otherwise Specified were included in this category. The second category was called "Non-Psychotic Major" and included those diagnoses that were major mental illnesses but that did not include psychotic symptomatology. Disorders such as Organic Mental Disorder Not Otherwise Specified, Depression, and Bipolar Disorder Hypomanic were included in this category. The third category was called "Non-Psychotic Minor" and included those minor disorders that did not involve psychotic symptomatology. Disorders that fell into this category included the personality disorders, Dysphoria, and Adjustment Disorder. The fourth category was called "Alcohol" and included those diagnoses that were alcohol related. The final category was called "Drug" and included those diagnoses that were drug related. If an individual was diagnosed as having a drug induced psychotic disorder, they would then be categorized as having both a "Psychotic" disorder as well as a

"Drug" disorder. The diagnoses given by the psychiatrists for each individual and their respective coded categories are found in Appendix C.

The final variable that had to be re-coded from the file information was the determination of the court as to fitness. This information was unavailable from the files at FPI and so it was reconstructed from the available information. The decision as to fitness made by the psychiatrist was compared with the eventual discharge status for each individual. There were six different scenarios that occurred. First and most common was when the psychiatrist recommended that the individual was fit to stand trial and the individual was discharged under a remand status and was not readmitted to FPI after the court date, it was assumed that the court agreed with the psychiatrist's recommendation and found the individual fit to stand trial. These individuals were coded as fit to stand trial. Second, if the psychiatrist recommended that the individual was unfit to stand trial and the individual's status changed to "unfit" while at FPI, then it was assumed that the court agreed with the psychiatrist and found the individual unfit to stand trial. These individuals, therefore, were coded as unfit to stand trial. Third, if the psychiatrist recommended that the individual be found fit to stand trial and then the individual's status was changed to "involuntary", it was assumed that the court found the individual fit to stand trial and that the individual was then remanded to FPI for treatment, although not as an unfit defendant. These individuals were coded as fit to stand trial. Fourth, if the individual's status changed to "NCRMD" then it was assumed that the court decided that the individual was fit to stand trial, independent of what the psychiatrist may have recommended. These individuals were coded as fit to stand trial. Fifth, a few individuals were found fit by the psychiatrist but were then immediately sent back to FPI by the court for another fitness evaluation. In this case it was assumed that the court disagreed with the decision of the

psychiatrist and accordingly, these individuals were coded as unfit to stand trial. Finally, there were a few cases where the psychiatrist recommended that the individual was unfit to stand trial but then the individual either did not go back to FPI after the court date or did go back as "involuntary" status. In these cases the court registry was contacted to determine what happened when the individual went to court. The psychiatrist's decision, outcome, and coded court decision for each individual can be found at Appendix D.

Statistical Analysis. Chi-squares were used to determine how well the psychiatrist's recommendation matched the decision about fitness made by the court. As well, chi-squares were used to compare those individuals that were recommended as fit with those who were recommended as unfit. Comparisons were also made between diagnoses and the types of crime committed. Finally two analyses were done to try to replicate some previous results found with similar samples by two different sets of researchers: Hart and Hare (1992) and Reich and Wells (1985).

Results

The results are presented in five sections to parallel the analyses that were done. First, a comparison was made between the psychiatrists' determination of fitness and those made by the court. Second, the fit and unfit defendants were compared to determine if there were any differences between the two groups. Specifically, the two groups were compared on demographic, mental health, and criminological variables. Third, comparisons were made between an individual's diagnoses and the types of crimes that were committed. Fourth, the predictive power of certain demographic, clinical, and criminal variables was examined in the same manner used by Hart and Hare (1992). Finally, the predictive efficiency of the logit model developed by Reich and Wells (1985) was examined.

Psychiatrist Decision versus Court Decision

When the psychiatrists' decisions about fitness were compared to the coded court decisions, it was found that the court almost always accepted the recommendation of the psychiatrist, χ^2 (1, $\underline{N}$ = 176) = 109.55, $\underline{p}$ < .0001. The court agreed with the psychiatrists' decisions regarding fitness on 169 of 176 cases (154 agreements of Fit; 15 agreements of Unfit) and disagreed on a total of 7 cases ($\underline{r}$ = .79, $\underline{p}$ < .0001). This was a high level of agreement even when chance was taken into account, kappa = .79. On those cases where there was disagreement, three were found fit by the psychiatrists and unfit by the court and four were found unfit by the psychiatrists and fit by the court. This high rate of agreement is not surprising when one considers the importance that has been placed upon the role of mental health professionals in the assessment of fitness (see Roesch & Golding, 1980; Whittemore & Ogloff, 1992). The predictive efficiency of the psychiatrists' recommendations of unfitness with respect to the court decisions was as follows (see bottom of Table 6 for an explanation of

predictive efficiency): sensitivity (SENS) = .83; specificity (SPEC) = .98; positive predictive power (PPP) = .79; negative predictive power (NPP) = .98. Since there was such a high rate of agreement between the psychiatrists' decisions and the court's decisions, only the psychiatrists' decisions were used for the remainder of the analyses in this study.

<u>Comparison of the Fit and Unfit Defendants</u>

The entire sample of remands was divided into two groups for the purposes of this comparison, those who were recommended fit to stand trial and those who recommended unfit to stand trial according to the report to court written by a psychiatrist. Table 1 summarizes the demographic data for the fit and unfit groups. These results can be interpreted in two different ways. First, the fit defendants can be compared to the unfit defendants to determine which demographic characteristics distinguish between the two groups. Second, the fit and unfit defendants can be grouped together and examined to determine the characteristics of those individuals who are being referred by the courts for fitness evaluations. It is evident that the fit and unfit groups do not differ greatly from each other on most of the demographic variables. There was, however, one significant difference that should be noted. When marital status was collapsed into those who had never been married (single) versus those who had ever been married (married, divorced, separated, common-law), there were significantly more unfit individuals who had never been married, χ^2 (1, $\underline{N}$ = 178) = 5.59, $\underline{p}$ < .05. When the characteristics of the entire referred group were examined, it was determined that the characteristics of this sample were quite similar to previous studies that had been conducted in BC (Roesch et al, 1981; Webster, Menzies, Butler, & Turner, 1982). The defendants who were referred for fitness evaluations were primarily single, were largely unemployed, and were mostly living alone at the time of admission to FPI.

There were no differences between the fit and unfit defendants on mental health variables such as previous mental health contact, previous psychiatric hospitalizations, previous use of psychiatric medications, or previous remands for fitness assessments. When looking only at the presence or absence of certain diagnoses, it was determined that those who were found unfit were four times more likely to have been given a diagnosis of a psychotic disorder, χ^2 (1, $\underline{N} = 178) = 6.16$, $\underline{p} < .05$, whereas those who were found fit were about equally as likely to have been diagnosed with a psychotic disorder as not. There were no differences between the fit and unfit defendants with regards to the prevalence of non-psychotic major and non-psychotic minor disorders. However, those who were found unfit were significantly less likely to have been given a diagnosis of an alcohol use disorder, χ^2 (1, $\underline{N} = 178) = 4.32$, $\underline{p} < .05$, or a drug use disorder, χ^2 (1, $\underline{N} = 178) = 7.32$, $\underline{p} < .01$. Table 2 shows the differences between the fit and unfit defendants on the presence of each of the five categories of disorders.

The relationship between fitness and diagnoses was also examined with regard to the most serious diagnosis given to each individual as shown in Table 3. If an individual had a psychotic disorder then he[3] was categorized as "psychotic disordered", regardless of the presence of any other disorders. If an individual did not have a psychotic disorder, then he was categorized as either "non-psychotic major disordered" or "non-psychotic minor disordered" dependent upon the most serious diagnosis with the major diagnoses being considered more serious than the minor diagnoses. As well, those individuals who had only alcohol or drug use disorders were classified as "substance disordered". As can be seen and would be expected, the distribution of most serious type of

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[3] When referring to the results that pertain to the present studies, "he" is used as there were no females included in the sample.

diagnosis differed for fit and unfit defendants, χ^2 (4, $\underline{N}$ = 178) = 10.65, $\underline{p}$ < .05. A greater proportion of the unfit defendants had diagnoses of psychotic disorders as the most serious diagnosis, χ^2 (1, $\underline{N}$ = 178) = 6.16, $\underline{p}$ < .05. This is not surprising when one considers the strong relationship that has previously been demonstrated between psychosis and the determination of unfitness (see Hart & Hare, 1992; Nicholson & Kugler, 1991; Roesch et al., 1981). Also, it was significant that none of the defendants who were found unfit had a primary diagnosis of a non-psychotic minor disorder, χ^2 (1, $\underline{N}$ = 178) = 7.18, $\underline{p}$ < .01. There was one individual who was found unfit but did not have a diagnosis. This individual was mute (by visitation from God rather than by malice) and eventually had his proceedings stayed by the court. Table 4 shows the comparison between fit and unfit defendants who had comorbid disorders, that is, a diagnosis of a psychotic disorder as well as a substance use disorder. There was a 17.4% rate of comorbid disorders in this sample which is comparable to the 21% rate found in a population of Canadian jail detainees by Turner (1994). It was determined using chi-square analyses that there were no significant differences between these two groups of defendants on the presence or type of comorbid disorders. Only one defendant who was deemed unfit had a comorbid disorder whereas the other nineteen did not.

A large proportion (70%) of the remands were treated with psychiatric medications while at FPI. This includes a number of individuals (53%) who were certified under the MHA while on remand. Of the 158 individuals who were found fit by the psychiatrists, 78 (49%) were, nevertheless, certified while on remand status at FPI. Those individuals who were recommended fit by the psychiatrist were significantly more likely to have been on medications (coded yes, no, not mentioned) while detained at FPI, χ^2 = (2, $\underline{N}$ = 178) = 6.55, $\underline{p}$ < .05. As well, of those who were recommended unfit by the psychiatrists, a

significantly larger proportion were certified under the MHA, $\chi^2 = (1, \underline{N} = 178) =$ 9.06, $\underline{p} < .01$.

When the assessment orders were examined to determine the length of time for which individuals were remanded in this sample, it was found that the average remand was 20.18 days (SD = 11.44) and the most prevalent remand length (i.e., mode) was 30 days. The range was from 2 - 60 days, not including any extensions to the orders. In fact, there were only 60 individuals (33.3%) who were actually remanded for a period of 9 days or less which should be about the maximum amount of time if we reserve 2 days for travel to and from the institution and another 2 for a weekend (see Figure 1). When the actual amount of time that individuals remained on remand at FPI was examined, the average length of time was 22.59 days (SD = 15.20) and the range was 3 - 114 days (see Figure 1). Only 50 (27.8%) of the total remands were actually released from FPI after being remanded for 9 days or less. There were 129 (71.7%) individuals who were released after being remanded for a period of 29 days or less which means that 28.3% were still held at FPI on remand status after being there for 30 days to a maximum of 114 days. The amount of time that elapsed from the date of admission to the date that the report was written by the psychiatrist with a decision as to fitness was also examined. The number of days it took to make a decision of fitness ranged from 2 - 51 and averaged 15.62 days (SD = 10.13). This translated into an average of 6.87 days (SD = 11.29) that an individual remained at FPI after a decision had been made regarding his fitness.

There were no significant differences between those found fit and those found unfit with regards to any of the criminological variables. The two groups were similar in their committal of violent, property, and miscellaneous offences (see Table 5). Both groups were equally as likely to have had a previous

criminal history and to have previously been in prison. It does not appear that the criminological variables had an effect on the decision of fitness.

Table 1

Fit Defendants vs. Unfit Defendants on Demographic Data

Category	Fit		Unfit	
Age	$\underline{M}$ = 35.18 ($\underline{SD}$ = 11.96)		$\underline{M}$ = 5.05 ($\underline{SD}$ = 11.93)	
Marital Status:				
Single	57.6%	(91)	85.0%	(17)
Married	12.7%	(20)	10.0%	(2)
Divorced	13.9%	(22)	5.0%	(1)
Separated	10.1%	(16)	0.0%	(0)
Common-law	5.7%	(9)	0.0%	(0)
Ethnic Group:				
Native	10.8%	(17)	5.3%	(1)
White	69.6%	(110)	63.1%	(12)
Asian	2.5%	(4)	10.5%	(2)
Other	17.1%	(27)	21.1%	(4)
Education:				
Elementary	8.9%	(14)	10.0%	(2)
Jr. High (Gr. 8-10)	31.0%	(49)	20.0%	(4)
Sen. High (Gr. 11-12)	32.9%	(52)	40.0%	(8)
Post-Secondary	9.5%	(15)	15.0%	(3)
University	13.9%	(22)	5.0%	(1)
Unknown	3.8%	(6)	10.0%	(2)
Employment (at admission):				
Unemployed	70.9%	(112)	75.0%	(15)
Part-time or Occasional	5.7%	(9)	0.0%	(0)
Full-time	8.9%	(14)	5.0%	(1)
Retired or Other	14.6%	(23)	20.0%	(4)
Living Status:				
Alone	45.9%	(72)	52.6%	(10)
With family	33.1%	(52)	21.1%	(4)
Other	21.0%	(33)	26.3%	(5)
Dwelling (at admission to FPI):				
House/Apartment	74.7%	(118)	73.7%	(14)
Hotel	7.6%	(12)	0.0%	(0)
No Fixed Address	10.7%	(17)	10.5%	(2)
Other	7.0%	(11)	15.8%	(3)

The first number indicates the percentage of group total. The number in parenthesis represents the number of subjects.

Table 2

Fit Defendants vs. Unfit Defendants on Psychiatric Diagnoses[a]

Category	Fit		Unfit	
Psychotic Disorders*	50.6%	(80)	80.0%	(16)
Non-Psychotic Major Disorders	10.8%	(17)	15.0%	(3)
Non-Psychotic Minor Disorders	35.4%	(56)	20.0%	(4)
Alcohol Use Disorders*	25.9%	(41)	5.0%	(1)
Drug Use Disorders**	34.8%	(55)	5.0%	(1)

The first column indicates the percentage of group total. The number in parenthesis represents the number of subjects.

[a]The percentage will not total 100% because an individual may have more than one type of disorder.
* $p < .05$
** $p < .01$

Table 3

Fit Defendants vs. Unfit Defendants on Most Serious Type of Diagnosis

Category	Fit		Unfit	
Psychotic Disordered*	50.6%	(80)	80.0%	(16)
Non-Psychotic Major Disordered	9.5%	(15)	15.0%	(3)
Non-Psychotic Minor Disordered**	27.2%	(43)	0.0%	(0)
Substance Disordered	8.9%	(14)	0.0%	(0)
No Diagnosis	3.8%	(6)	5.0%	(1)

The first column indicates the percentage of group total. The number in parenthesis represents the number of subjects.

* $p < .05$
** $p < .01$

Table 4

Comparison of Fit vs. Unfit Defendants on Comorbid Disorders

Category	Fit		Unfit	
No Comorbidity	81.0%	(128)	95.0%	(19)
Psychotic & Drug Use	12.0%	(19)	5.0%	(1)
Psychotic & Alcohol Use	5.1%	(8)	0.0%	(0)
Psychotic & Both Drug and Alcohol Use	1.9%	(3)	0.0%	(0)

The first column indicates the percentage of group total. The number in parenthesis represents the number of subjects.

Table 5

Fit Defendants vs. Unfit Defendants on Most Serious Type of Offence

Category	Fit		Unfit	
Violent	74.0%	(117)	75.0%	(15)
Property	18.4%	(29)	20.0%	(4)
Miscellaneous	7.6%	(12)	5.0%	(1)

The first column indicates the percentage of group total. The number in parenthesis represents the number of subjects.

Figure 1

Comparison of the Length of Time Specified on the Remand Orders and the Actual Length of Time at FPI on Remand
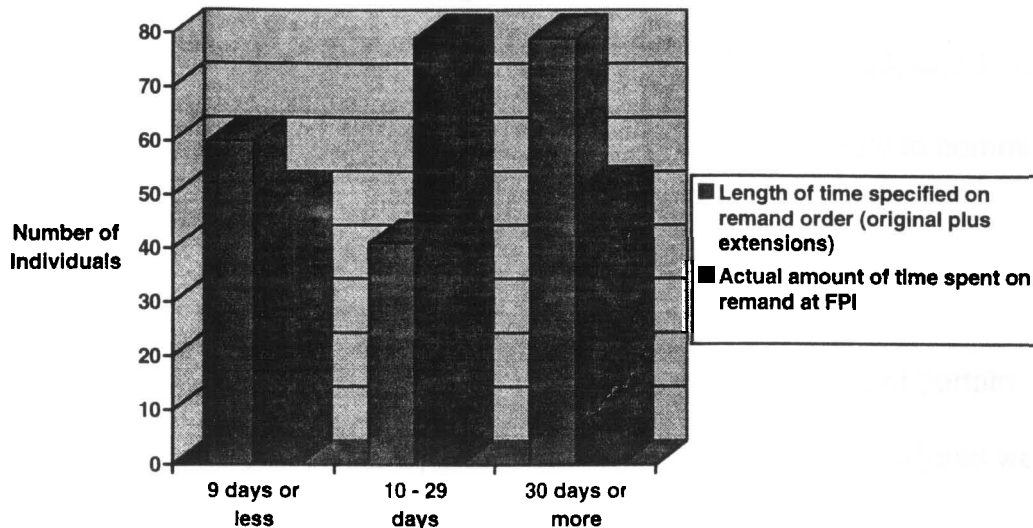
Comparison of Diagnoses and Type of Offence Committed

When comparisons were made between an individual's diagnoses and the types of crimes committed, most of the significant results that were found pertained to those individuals who had been diagnosed as having non-psychotic minor disorders. Those individuals who had diagnoses of non-psychotic minor disorders were less likely to commit miscellaneous offences, χ^2 (1, $\underline{N}$ = 180) = 4.16, $\underline{p}$ < .05, as well as both violent and miscellaneous offences, χ^2 (1, $\underline{N}$ = 180) = 6.38, $\underline{p}$ < .05, and property and miscellaneous offences, χ^2 (1, $\underline{N}$ = 180) =

4.76, $p < .05$. Those individuals who had been given diagnoses of drug use disorders were significantly less likely to commit only miscellaneous offences, χ^2 (1, $N = 180$) = 4.22, $p < .05$. There were also trends in the data that suggested that those individuals who had diagnoses of alcohol use disorders were more likely to commit violent offences, χ^2 (1, $N = 180$) = 3.58, $p = .058$, and that individuals with diagnoses of psychotic disorders were less likely to commit miscellaneous offences, χ^2 (1, $N = 180$) = 3.38, $p = .066$.

Predictive Efficiency of Demographic, Criminal, and Clinical Variables

Hart and Hare (1992) reported the predictive efficiencies of certain individual demographic, clinical, and criminal variables. Their analyses were replicated here to determine if these variables predict unfitness for this sample in the same manner as they did for Hart and Hare (1992)[4]. The predictive power of each of the variables is shown in Table 6. The only variables that were significantly associated with decisions of fitness were the clinical variables. Specifically, a diagnosis of schizophrenia was the single best predictor of unfitness, followed next by a psychotic diagnosis. In contrast, a diagnosis of drug use or dependence was associated with a finding of fitness as was a diagnosis of alcohol use or dependence. These clinical variables were the only variables that were associated with the psychiatrists' decisions of fitness. None of the demographic or criminal variables were significantly related to fitness in this sample.

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[4] For a complete description of the procedures used in this analysis and the coding of the variables, the reader is referred to Hart and Hare (1992).

Reich and Wells (1985) Logit Model

The data for this sample were analyzed using the logit regression model described by Reich and Wells (1985).[5] The diagnoses in the original model were substituted with the equivalent DSM-III-R diagnoses that were used by the psychiatrists at FPI. A regression score was computed for each subject and those over 0.5 were classified as being predictive of fitness. The logit model was found to be significantly related to the decisions of fitness made by the psychiatrists, χ^2 (1, $\underline{N}$ = 156) = 5.86, $\underline{p}$ < .05. The predictive efficiency of this model was as follows: SENS = .65, SPEC = .66, PPP = .19, NPP = .94, kappa = .14. The predictive efficiency of this model with the present sample was very similar to the predictive efficiency that was reported in the original sample tested by Reich and Wells (1985) ten years earlier.

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[5] For a complete description of the procedures used in this analysis, the reader is referred to Reich and Wells (1985). The model is logit competency = 0.914 - 0.945 schizophrenia + 1.409 transient/low morbidity - 0.613 repeat, where schizophrenia is a primary Axis I diagnosis of schizophrenia; transient/low morbidity is a primary Axis I or II diagnosis other than schizophrenia, organic brain syndrome, affective disorder, personality disorder, or mental retardation; and repeat is a history of previous remands within the past 2 years (all coded 0 = no, 1 = yes).

Table 6

Predictive Efficiency of Demographic, Criminal, and Clinical Variables with Respect to Psychiatrists Decisions of Unfitness

Variable	p[a]	Predictive Efficiency				
		SENS	SPEC	PPP	NPP	Kappa
Demographic Variables						
Age	--	.60	.37	.11	.88	-.01
Race	--	.37	.70	.13	.90	.04
Marital Status	--	.90	.18	.12	.94	.02
Education	--	.33	.59	.09	.88	-.04
Criminal Variables						
Adult Record	--	.80	.16	.09	.89	-.01
Violent Offence	--	.75	.26	.11	.89	.00
Clinical Variables						
Any Major Axis I	--	.90	.25	.13	.95	.04
Schizophrenia	.001	.60	.75	.24	.94	.21
Any Psychotic	.013	.80	.49	.17	.95	.11
Alcohol Use	.038	.05	.74	.02	.86	-.14
Drug Use	.007	.05	.65	.02	.84	-.17
Any Axis II PD	--	.05	.80	.03	.87	-.12
APD	--	.00	.95	.00	.88	-.07
Previous Trtmt	--	1.0	.14	.13	1.0	.04
Previous Remands	--	.41	.70	.14	.91	.06

SENS, sensitivity (probability predictor variable is positive given a recommendation of unfit); SPEC, specificity (probability predictor variable is negative given a recommendation of fit); PPP, positive predictive power (probability of a recommendation of unfit given predictor variable is positive); NPP, negative predictive power (probability of a recommendation of fit given predictor variable is negative); Kappa, kappa coefficient of agreement between predictor variable and recommendations of unfitness.

[a]Significance of χ^2 test of the association between predictor variable and fitness decisions; -- means no significant association. $\underline{N}$ = 178, df = 1 for all tests.

Discussion

Prior research has indicated that the courts rarely disagree with the recommendations of fitness made by mental health professionals (see Hart & Hare, 1992; Reich & Tookey, 1986; Roesch & Golding, 1987). The results of the comparisons made here between the decisions made at FPI and the court decisions show this same high rate of agreement. In the large majority of cases, the defence and the prosecution will both agree with the recommendations of the psychiatrist in the report to the court and therefore, a decision about fitness will be made without having an actual hearing on the issue. Those who are found fit will continue on with their court proceedings and those who are found unfit will, most likely, be sent to an inpatient facility until their fitness has been restored. The only problem with this has been discussed before by Roesch and colleagues at length (see Roesch & Golding, 1980; Roesch et al., 1981). That is, there is no way of ever really knowing for sure if a decision of unfit was the correct one. As a decision of unfit to stand trial postpones the pending trial, there is no opportunity to observe directly if the defendant was truly unable to conduct a defence. This appears to be a problem that most likely will not be solved in the near future, although Roesch and Golding (1980) proposed a possible solution. They argued that a possibly unfit defendant be allowed to proceed with his or her trial and, if at the end of the trial, it is determined that the accused was in fact unable to assist in his or her own defence, then the verdict should be set aside and a new trial ordered once the individual's fitness has

been restored. This would allow those with questionable fitness to proceed with their trials instead of having them postponed for an indeterminate period of time. In this way, the characteristics of each case and each individual are taken into consideration when making a determination of fitness.

A recent report submitted to the Department of Justice by Roesch, Ogloff, and Hart (1993) indicated that the sample of fitness remands during the 1992-1993 fiscal year in British Columbia were mainly single males with almost half having less than grade 10 education. Another study conducted by Roesch et al. (1981) in British Columbia approximately 10 years earlier showed the same pattern of remands. Webster et al. (1982) examined a sample of remands from six major Canadian cities and found that the majority were single, male, and had "characteristically low" educational histories (p. 457). Although the current sample was very similar to these other studies that had been conducted in BC, there were some differences between this sample and the results of previous studies. For example, Roesch et al. (1981) found that the majority of their referred sample had not finished high school and reported that 60% of their sample "completed only junior high or less" (p. 149). Roesch et al. (1981) also reported that approximately 11% of their sample had university education. It is evident that the present sample differs from that of Roesch et al. (1981) in that only 38.9% of this sample had only completed junior high or less and approximately 23% had some post-secondary education. If we examine the education rates in the Webster et al. (1982) study we see approximately the

same pattern as in the Roesch et al. (1981) study with reports that "36% had grade 8 or less, 30% completed grade 9 or 10, 23% had grade 11 to 13 education, and only 10% gained at least some post-secondary education" (p. 457). The sample collected in 1992-1993 by Roesch et al. (1993), however, reported that approximately 53% had education at the grade 10 level or higher. From this, it is evident that there has been a pattern of slightly increasing education levels among fitness remands since the 1980s. This may reflect an overall rise in the education level of the general population. In recent decades the economy has been falling and high unemployment rates have been forcing individuals to get more education in order to gain employment. The education level of the present sample of remands may be reflective of a general increase in education level and the explanation for the continued high rate of unemployment among these remands may be because they still have lower education rates than the rest of the population.

Roesch et al. (1981) found that 27% of their sample were transient at the time of arrest whereas in this sample, approximately 11% had no fixed address at the time of admission to the Forensic Psychiatric Institute. A recent study conducted using a pretrial population in Vancouver, BC found that the rate of homelessness among pretrial detainees was approximately 8% (Roesch, Hart, & Zapf, 1995). The lower rate of "homelessness" in both the pretrial study and the current study may indicate a decrease in the number of homeless offenders

since the late 1970s or it may suggest that fewer homeless individuals are being arrested and/or detained for their crimes.

The question of whether fit and unfit defendants differ from each other on certain demographic variables remains unclear. Nicholson and Kugler (1991) conducted a meta-analysis of 30 studies that compared fit and unfit defendants. These researchers reported that fit and unfit defendants differed from each other with regard to four demographic characteristics: age, gender, race, and marital resources. Their results indicated that unfit defendants were more likely to be older, female, members of minority groups, and to have fewer marital resources. This meta-analysis used studies conducted in both the United States and Canada. A retrospective study of fitness remands conducted over an eight-year period in Canada found significant differences between fit and unfit defendants on race and age (Rogers, Gillis, McMain, & Dickens, 1988). These researchers found that questionably fit and unfit defendants were more likely to be non-White and older than were fit defendants. Hart and Hare (1992), however, found "no evidence that fitness decisions were biased with respect to demographic variables such as age or race" (p. 62). As well, Roesch et al. (1981) found that the only two demographic variables that significantly distinguished between fit and unfit defendants were living status and dwelling at the time of arrest. In the current study, there were no significant differences found that distinguished between fit and unfit defendants with the exception of marital status. This difference may be explained in terms of the relationship between mental illness

and social isolation. That is, individuals with severe mental illnesses often have difficulty in maintaining interpersonal relationships (Robins, Locke, & Regier, 1991). Those individuals who are unfit to stand trial are often extremely mentally ill and therefore it makes sense that more of them do not have close relationships with other people.

There have been varying reports of the base rate of "unfitness". Grisso (1986) reported that the numbers ranged from as high as 77% to as low as 4% in the United States. In Canada, the numbers that have been reported have been similar in range (Roesch, 1978c). When the data for six Canadian cities was pooled, the base rate of unfitness in the sample was 15.3% (Menzies et al., 1980). Another retrospective study conducted in Toronto again found a 15% rate of unfitness in a sample of fitness remands (Rogers et al., 1988). Hart and Hare (1992) found a 31% rate of unfitness in their sample of 80 males remanded for inpatient fitness assessments in British Columbia. Roesch et al. (1993) reported a 15% rate of unfitness. The current study had a 11.2% rate of unfitness based upon the psychiatrists' decision of fitness and a 10.2% rate when the coded court determination of fitness was used. The rate of unfitness found in this sample appears to be similar to those rates found in other Canadian studies with the exception of Hart and Hare (1992). The difference in the rates between the present sample and that of Hart and Hare (1992) is probably due to differences in the coding of fitness for those individuals whose proceedings were stayed.

Many researchers have found that the majority of fitness remands have had histories of psychiatric problems and hospitalizations (see Hart & Hare, 1992; Roesch et al., 1981; Webster et al., 1982). The present sample is no exception. There was a large proportion of the sample that had previous contact with mental health professionals, that had previously been hospitalized for mental health problems, and that had previously been on psychiatric medication. This may, in part, account for the high proportion of fitness remands that are found fit to stand trial. The fact that an individual has had previous contact with mental health services may predispose him to being remanded for a fitness evaluation.

When the relationship between fitness and psychiatric diagnoses was examined, it was found that a significantly higher proportion of the unfit defendants had diagnoses of psychotic disorders. This is to be expected as the legal concept of unfitness is often associated with the psychiatric concept of psychosis. If we think of the colloquial expressions "mad" and "bad", there are two types of groups that are remanded for fitness evaluations: those that are more "mad" than "bad" (or more mentally ill than criminal) and those that are more "bad" than "mad" (or more criminal than mentally ill). The former group is often remanded because they are mentally ill and they do things that are more dangerous than criminal whereas the latter group is often remanded because they do criminal things but display mental health symptoms. We would expect that a large percentage of the unfit individuals will fall into this former group. If

we equate psychosis with unfitness, then it makes sense to have more unfit

defendants with diagnoses of psychotic disorders. There is, however, a large

proportion of fit defendants in this sample who had been diagnosed with

psychotic disorders. As has been indicated in previous research, not all

psychotic defendants are unfit to stand trial and psychosis is not necessarily

equivalent to unfitness (Golding, Roesch, & Schreiber, 1984). Other

researchers (i.e., Grisso, 1986; Roesch & Golding, 1987; Roesch, Ogloff, &

Golding, 1993; Rogers & Mitchell, 1991) have discussed the necessity of taking

the contextual demands of each case into consideration when making a

determination as to an individual's fitness, rather than only the individual's

mental functioning. It is quite usual for a defendant with a specific mental

disorder to be competent for one type of legal proceeding but incompetent for

another (Roesch, Ogloff, & Golding, 1993). It is therefore, important to consider

each individual's mental functioning in relation to the specific legal case that he

or she is involved in when making a determination of fitness.

It is of interest to note the large number of individuals who were treated

with psychiatric medications and who were certified under the MHA while on

remand status at FPI. The Code states that no assessment order may specify

that treatment of an accused be carried out or direct an accused to submit to

treatment. Nevertheless, many individuals in this study were certified and

treated involuntarily while on remand at FPI. Technically, this is not against the

law as the treatment is not being ordered on the assessment form but these

individuals are still being treated while on remand. Although definitive data are not available, it was determined from the files that a large number of these individuals initially refused treatment in the form of psychiatric medications and this therefore, suggests that these individuals were sometimes being treated against their will. It seems as if the psychiatrists may be taking it upon themselves to restore the individual to fitness before he or she has had a chance to go to court for the first time. There were a few psychiatrists who noted in their reports to the court that the individual was unfit upon admission to FPI and therefore was certified and placed on medication and subsequently restored to fit by the time the report had gone to court. This is an important point as it may account for why a significant proportion of those who were certified were eventually found fit to stand trial. It is important to note that many more individuals are medicated while on remand than are certified. Only those who refuse treatment and are found to be dangerous to themselves or others are certified. Those individuals who do not refuse treatment can be medicated while on remand without being certified.

In 1992 Bill C-30 changed the length of time that an individual could be remanded from 30 days to 5 days. As seen when we look at the results for the average length of time that an individual is remanded for in this study, the 5-day assessment order is rarely used and the 30-day assessment order remains the most prevalent type. As well, there is often a discrepancy between when the decision of fitness was made by the psychiatrist and when the individual was

released from FPI. It is apparent from the files that these individuals are being held at FPI until they go to court. This appears to be a major policy problem. These individuals are being detained and denied their liberty whereas others, who may have committed similar crimes but for whom there was no assessment ordered, may be awaiting their trials while out on bail. Simply because an individual was remanded for an assessment of his or her mental condition does not mean that he or she should be deprived of his or her liberty until the case goes to trial.

There were no significant differences found between fit and unfit defendants on the types of crimes that they commit. Other studies have also indicated that fit and unfit defendants do not differ on the types of crimes that they commit (see Nicholson & Kugler, 1991; Roesch et al., 1981). This sample had a larger proportion of individuals who committed violent offences or offences against persons and a smaller proportion of individuals who committed property or miscellaneous offences as compared to the Roesch et al. (1981) study. This may be a result of the crime trends in Canada. Since 1983 the rate of violent offending has increased dramatically whereas the rates of property and miscellaneous offences have shown a small but steady increase (Ogrodnik, 1994). The higher rate of violent offences in this sample as compared to the 1981 sample may reflect this general increase in violent offending. Steadman (1979) suggested that unfit defendants commit more violent offences than do fit defendants whereas Melton, Petrila, Poythress, and Slobogin (1987) argued that

this high proportion of serious or violent offences that the unfit group is charged with may be reflective of the relative seriousness of the charges facing the entire group of referred defendants. This latter proposition appears to be supported in the present study as both the fit and unfit defendants were remanded mainly for violent offences. The 1993 crime statistics indicate that of the total federal statue incidents reported, 10% were violent offences, 53% were property offences, 30% were other types of offences, and 7% were traffic offences (Ogrodnik, 1994). When the percentages of the crimes in this sample are compared to those reported in 1993, violent offences are about seven times higher in this sample, property offences are about three times higher, and other/miscellaneous offences are about three times lower. In a recent study conducted by Roesch (1995) that examined a pretrial jail population in Vancouver, BC, it was determined that the rate of violent offending among jail detainees was 25.9%. This was found to be comparable to the national rate of 26.5% that was reported by the Canadian Centre for Justice Statistics in 1986. It is evident that the rate of violent offending in the present sample of remands is far higher than both the pretrial jail sample of Roesch (1994) or the national sample of custodial remands. It may be that the criminal justice system is filtering those individuals who have committed less serious offences rather than sending them for inpatient fitness assessments. Roesch and Golding (1980) have argued that fitness evaluations are a greater risk for those who have committed relatively minor offences as they may spend more time in mental

health facilities than they would have in jail if they had been found guilty of their offences. Currently, Bill C-30 has capping provisions in place to set a limit on the amount of time that an individual can be held in a mental health facility after being found unfit to stand trial, however these have yet to be proclaimed. It is, therefore, still possible for individuals who have been found unfit to stand trial to be detained longer in a mental health facility than the maximum sentence for their offence if they had gone to trial and had been found guilty.

Upon examination of the present study and past research it can be seen that there are two issues that need to be addressed. First, is the current sample representative of other samples of remands in BC and Canada? The answer is a definitive yes. The present sample appears to be very typical of other samples of remands that have been studied in BC and Canada over the past two decades. Second, are the differences between fit and unfit defendants found in this study similar to those differences found between fit and unfit defendants in other studies? The answer to this question is less definitive. In the present study, the main differences between the fit and unfit defendants were on diagnoses of psychotic disorders and marital status. These same differences have been found to be fairly robust across different studies. There were, however, differences that have been previously reported between fit and unfit defendants on certain other demographic variables that have not been found in the present study.

With respect to the relationship between diagnosis and type of crime, this sample does not confirm the results of other studies that have found a positive relationship between psychosis and violent crime (see Douglas & Hart, 1995). It appears that in this sample, those individuals with psychotic disorders did not commit more violent crimes than did those individuals who do not have psychotic disorders. Perhaps the relationship between psychosis and violent crime that has been found previously has been confounded by other mental health variables such as non-psychotic minor disorders or drug and alcohol use disorders. In this sample, 17.4% had comorbid disorders and 7.9% had both a psychotic diagnosis as well as a non-psychotic minor diagnosis. As well, there was a trend in this sample that suggested that individuals with alcohol use disorders were more likely to commit violent crimes. Other researchers have reported that when examining the relationship between psychosis and violent crime in populations such as the present sample, a significant relationship is not always found because of the high base rate of psychosis in these samples (Douglas & Hart, 1995).

The most effective predictors of fitness in this sample were clinical variables. Clinical variables were also reported by Hart and Hare (1992) to be the most effective predictors of fitness. Whereas, Hart and Hare (1992) found that a diagnosis of any psychotic disorder was the most effective predictor, in this study, specifically a diagnosis of schizophrenia was the most effective predictor of unfitness and any psychotic diagnosis (including schizophrenia) was

a slightly less effective predictor. As well, Hart and Hare (1992) found that a diagnosis of Antisocial Personality Disorder was an effective predictor of an individual's fitness whereas in the present study, a drug abuse or dependence diagnosis was found to be an effective predictor of fitness and a diagnosis of alcohol use or dependence was found to be a slightly less effective predictor of fitness. The two most important clinical variables for the prediction of unfitness were a diagnosis of schizophrenia and a diagnosis of a psychotic disorder in both Hart and Hare's (1992) sample as well as the present sample. The sensitivity and specificity for both of these variables were very similar in each of the studies. This is to be expected as the sensitivity and specificity tend to remain constant across samples whereas the NPP and the PPP are sample-specific and will change with different samples. These results support the conclusion of Hart and Hare (1992) that "a good first step in assessing fitness is a clinical screening for psychosis" (p. 63).

The logit model of Reich and Wells (1985) was found to be a useful predictor of fitness for the present sample. The fact that this model was found to be useful in predicting fitness suggests that diagnoses such as schizophrenia as well as previous remands for fitness evaluations are important factors in determining unfitness whereas low morbidity diagnoses are important to the determination of fitness. When the overall predictive efficiency of this model was compared to the overall predictive efficiency of the clinical variables, a diagnosis of schizophrenia was the best predictor of unfitness, followed next by

this logit model, and finally by a diagnosis of a psychotic disorder. However, when we are using these variables as a screening measure, it is important to have high sensitivity and high negative predictive power. This means that a diagnosis of a psychotic disorder would be the best variable to use for screening unfitness, followed next by the logit model and then by a diagnosis of schizophrenia.

Considering all of the results of this study, a few main points should be emphasized. First, there are too many individuals being remanded for fitness assessments who are clearly fit to stand trial. This is indicated by the high rate of fitness in this sample. Second, the one difference that consistently differentiates those who are unfit from those who are fit is a diagnosis of a psychotic disorder. Fitness is a legal construct and therefore should not and does not favor one particular set of demographic variables. It has, however, been demonstrated to have a strong relationship with certain diagnoses, particularly psychotic disorders. Third, individuals are being held for too long on remand. These remands are expensive and should be used wisely. These three main points appear to lead one in the same direction, toward the use of brief screening instruments. If one were to use a brief screening instrument to screen out those for whom there is no question as to their fitness, the result would be that less people would be remanded for fitness evaluations and valuable resources would be utilized sparingly. As Hart and Hare (1992) mentioned, screening for psychotic disorders appears to be a good first step, but

since not all psychotic individuals are unfit, it is also necessary that the

screening process assesses the legal construct of fitness. The next study

describes a screening instrument that was designed to assess the legal

construct of fitness, the Fitness Interview Test - Revised. The study attempts to

determine its predictive efficiency and usefulness as a screening instrument.

STUDY 2: A COMPARISON OF INSTITUTION-BASED EVALUATIONS AND

THE FITNESS INTERVIEW TEST - REVISED

Method

<u>Participants</u>

Participants for this study were drawn from a larger study examining the

relationship between mental disorder and different types of legal competencies.

The participants were selected on the basis of their admission to the Forensic

Psychiatric Institute (FPI) in Port Coquitlam, British Columbia. All male

admissions who were remanded for a fitness evaluation between October 11,

1994 and July 11, 1995 were eligible to take part in this study. The potential

participants were asked if they would like to volunteer to be interviewed by a

graduate student from Simon Fraser University for research purposes. Those

individuals who volunteered then had the procedure explained to them in detail

and were asked to sign a consent form (see Appendix E). There were 180

individuals remanded for fitness evaluations during this time period. The

researchers contacted 169 of these remands to ask them if they would like to

participate in the study. Of those contacted, 57 (33.7%) agreed to take part in

the study and another 6 would have taken part but were unable to give informed

consent due to the severity of their mental illness. The remaining 11 remands

were not contacted because the Christmas holidays and the researchers'

schedules did not permit them to see these individuals.

As illustrated in Table 7, most (80.4%) of the participants were White, single (52.6%), and unemployed (70.2%) at the time of admission to FPI. The average age at the time of testing was 33.49 (SD = 11.85) years. According to the files, 87.7% of the participants had previous contact with mental health professionals and 70.2% had previously been hospitalized for psychiatric problems. Also from the files, it was determined that 78.9% of the participants had previous criminal histories, 43.9% had previously been in prison, and 64.9% were currently remanded to FPI charged with offences against persons.

Procedure

File and Interview Information. Each of the participants were interviewed by a senior clinical psychology graduate student from Simon Fraser University and were administered a package of instruments that included the Structured Clinical Interview for DSM-III-R--Patient Edition (SCID-P; Spitzer, Williams, Gibbon, & First, 1990), the Fitness Interview Test - Revised (FIT-R), the Test of Charter Comprehension (TOCC; Ogloff & Olley, 1994), the Block Design and Vocabulary subtests of the Wechsler Adult Intelligence Test - Revised (WAIS-R; Wechsler, 1981), and were assessed as to criteria for Antisocial Personality Disorder (APD) according to the revised third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R; APA, 1987). The interview and package of instruments took approximately one to two hours to administer with the amount of time dependent upon the degree of impairment of the

individual. Only the FIT-R and the SCID results were used in this study. A brief

description of each measure follows this section.

Each participant was given $5 as remuneration for his participation in the

study. This amount was thought to be small enough that it would not be an

enticement for participation in the study, yet provide some compensation for the

participant's time.

• The file information that was collected for Study 1 was used for those

individuals who participated in Study 2 (see Appendix A). No names were

associated with the file information that was coded. All procedures were

approved by the appropriate university and institutional ethics review boards and

were in accordance with current ethical principles.

The Fitness Interview Test - Revised. The current research version of the

Fitness Interview Test (FIT-R; Roesch, Webster, & Eaves, 1994) takes

approximately 30 minutes to administer and consists of a structured interview

which taps into three main areas: (a) the ability to understand the nature or

object of the proceedings, or factual knowledge of criminal procedure, (b) the

ability to understand the possible consequences of the proceedings, or the

appreciation of personal involvement in and importance of the proceedings, and

(c) the ability to communicate with counsel, or to participate in the defence.

Each of these three sections is broken down into specific questions which tap

into different areas involved in fitness to stand trial. The first section assesses

the defendant's understanding of the arrest process, the nature and severity of

current charges, the role of key players, legal processes, pleas, and court procedure. The second section assesses the defendant's appreciation of the range and nature of possible penalties, appraisal of available legal defences, and appraisal of likely outcome. The final section assesses the defendant's capacity to communicate facts to the lawyer, relate to the lawyer, plan legal strategy, engage in his or her own defence, challenge prosecution witnesses, testify relevantly, and manage courtroom behavior.

Once the interviewer has completed the interview portion of the Fitness Interview Test - Revised, he or she then completes an overall assessment of the defendant's fitness to stand trial. The first component of this overall assessment is to determine whether or not the defendant has a mental disorder as defined in case law. For the purposes of the present study, this was determined by administering the Structured Clinical Interview for DSM-III-R (SCID). The second component of this overall assessment is to determine whether or not the individual was able to understand the nature or object of the proceedings, to understand the possible consequences of the proceedings, and to communicate with counsel. If there was an impairment in this second component and the individuals had a mental disorder as defined by case law, then the individual was judged to be unfit to stand trial. It should be noted that the criteria set out in Section 2 of the Code state that the impairment on legal abilities must be due to the mental disorder. When the interviewer is completing the overall assessment portion of the FIT-R, he or she only decides if the individual was impaired on any

of the legal criteria and whether or not the individual had a mental disorder as defined in case law. The interviewer does not assess whether any legal impairments were <u>due to</u> the mental disorder. As the FIT-R was designed to be a screening device used by trained individuals who are not necessarily clinicians or psychiatrists it is only necessary to establish the co-occurance of legal impairment and a mental disorder to be found unfit as these individuals will then be remanded for a fitness evaluation conducted by forensic mental health professionals.

<u>The Structured Clinical Interview for DSM-III-R</u>. The Structured Clinical Interview for DSM-III-R (SCID; Spitzer, Williams, & Gibbon, 1986) is a semi-structured interview that is used to make the major Axis I and Axis II diagnoses. For the purposes of this study, only certain Axis I diagnoses were made. These diagnoses included mood disorders, psychotic disorders, and psychoactive substance use disorders.

Spitzer, Williams, Gibbon, and First (1990) have noted that the reliability of the SCID is a function of the particular circumstances under which it is being used as it requires clinical judgment on the part of the interviewer. These researchers have also explained that the validity of the SCID is difficult to assess as the concept of validity refers to the degree of agreement between an instrument and some hypothetical "gold standard". As this "gold standard" remains elusive for psychiatric diagnoses, it is obviously difficult to compare it with the SCID.

Statistical Analysis. Chi-squares were used to determine how representative this sample of participants was of the entire sample of remands for this time period. As well, chi-squares were used to try to determine whether there were any differences between those the FIT-R called fit and those it called unfit and how well the FIT-R matched the decision about fitness made by both the psychiatrists as well as the court.

Results

The results are discussed below in three sections. First, the participant

sample was examined to determine if the participants were representative of the

entire sample of remands. Second, comparisons were made between those

defendants that the FIT-R called fit and those that the FIT-R called unfit to

determine if there were any differences between the two groups. These were

the same analyses as were conducted between the fit and unfit defendants in

Study 1. Finally, the fitness decisions made by the FIT-R were compared to the

decisions made by the psychiatrists at FPI to determine the predictive validity of

the FIT-R. The FIT-R decisions were also compared to the coded court

decisions.

Comparison of Participants and Non-Participants

The entire sample of remands was divided into two smaller groups, those

who participated in the study and those who did not. These two groups were

compared to determine how representative the participant sample was of the

entire sample of remands. There were no significant differences between the

participants and the non-participants on any of the demographic variables such

as age, marital status, ethnic group, education, employment status, or living

situation (see Table 7). When the ethnic groups were collapsed into two groups,

White versus all other ethnic groups, it was found that the participants were

more likely to be White, χ^2 (1, $\underline{N}$ = 179) = 4.70, $\underline{p}$ < .05. The first language of the

individuals may have been a confound here as a number of the non-participants

could not participate because they were not able to understand English well or did not speak the language at all.

The participants as well as the non-participants were equally as likely to have had prior contact with mental health professionals, to have been previously hospitalized for mental health problems, and to have previously been on psychiatric medication. When the two groups were compared as to the presence of each of the five major categories of diagnoses it was determined that the participants were significantly less likely than the non-participants to have been given diagnoses of psychotic disorders by the psychiatrist at FPI, χ^2 (1, $\underline{N} = 180$) = 6.15, $\underline{p} < .05$. This may have been due to the fact that the researchers had trouble getting informed consent from those individuals who were grossly psychotic and therefore it makes sense that the participant sample would be biased in the direction of fewer individuals with psychotic disorders. Both groups were equally as likely to have been given diagnoses of non-psychotic major disorders, non-psychotic minor disorders, and alcohol use disorders. The participants, however, were significantly more likely to have been given diagnoses of drug use disorders, χ^2 (1, $\underline{N} = 180$) = 9.50, $\underline{p} < .01$ (see Table 8). Each defendant was then categorized according to his most serious diagnosis in the same manner as Study 1. When the relationship between participant status (i.e., participant vs. non-participant) and most serious diagnosis was examined, a significant difference was found between the two groups, χ^2 (4, $\underline{N}$ = 180) = 12.72, $\underline{p} < .05$. That is, the non-participants were

significantly more likely to have had a psychotic disorder, χ^2 (1, $\underline{N}$ = 180) = 6.15, $\underline{p}$ < .05 and were significantly less likely to have had a substance use disorder, χ^2 (1, $\underline{N}$ = 180) = 9.26, $\underline{p}$ < .01, as the most serious diagnosis (see Table 9). Finally, there were no significant differences found between the two groups on the comorbidity of disorders (see Table 10).

Fewer of the participants had been certified under the Mental Health Act (MHA) while on remand when compared with the non-participants, χ^2 (1, $\underline{N}$ = 180) = 6.15, $\underline{p}$ < .05. This may have been a function of the severity of the individual's disorder. As was mentioned earlier, those individuals who were severely impaired could not give informed consent and therefore could not take part in the study. It makes sense that a large majority of these individuals were certified under the MHA. As well, those individuals who were not severely disordered (and probably not certified) may have been over-represented as participants because taking part in the study may have been an attractive alternative to spending time on the ward with the other severely disordered remands. The participants were significantly less likely to have been found unfit according to the psychiatrist's recommendation to the court, χ^2 (1, $\underline{N}$ = 178) = 5.02, $\underline{p}$ < .05. As well, the participants were significantly less likely to be decided to be unfit by the courts, χ^2 (1, $\underline{N}$ = 176) = 6.37, $\underline{p}$ > .05. Finally, there was a trend in the data that suggested that the participants were less likely to have been readmitted to FPI than were the non-participants, χ^2 (2, $\underline{N}$ = 179) = 5.82, $\underline{p}$ = .05.

When the criminological variables were examined, it was found that the two groups were equally as likely to have been remanded for miscellaneous offences, however, the participants were significantly less likely than the non-participants to have been remanded for violent offences, χ^2 (1, $\underline{N}$ = 180) = 3.98, $\underline{p}$ < .05. As well, the participants were significantly more likely to commit only property offences, χ^2 (1, $\underline{N}$ = 180) = 3.99, $\underline{p}$ < .05, and to have property offences as their most serious crime, χ^2 (1, $\underline{N}$ = 180) = 5.28, $\underline{p}$ < .05 (see Table 11). The two groups were equally as likely to have had a previous criminal history, to have previously been in prison, or to have previously been remanded for a fitness assessment.

Table 7

Participants vs. Non-Participants on Demographic Data

Category	Participants		Non-Participants	
Age	M = 33.49 (SD = 11.85)		M = 36.01 (SD = 12.11)	
Marital Status:				
Single	52.6%	(30)	64.2%	(79)
Married	12.3%	(7)	12.2%	(15)
Divorced	19.3%	(11)	10.6%	(13)
Separated	8.8%	(5)	8.9%	(11)
Common-law	7.0%	(4)	4.1%	(5)
Ethnic Group:				
Native	7.1%	(4)	11.4%	(14)
White	80.4%	(45)	64.2%	(79)
Asian	1.8%	(1)	4.1%	(5)
Other	10.7%	(6)	20.3%	(25)
Education:				
Elementary	14.1%	(8)	6.5%	(8)
Jr. High (Gr. 8-10)	31.6%	(18)	29.3%	(36)
Sen. High (Gr. 11-12)	33.3%	(19)	34.1%	(42)
Post-Secondary	10.5%	(6)	9.8%	(12)
University	10.5%	(6)	13.8%	(17)
Unknown	0.0%	(0)	6.5%	(8)
Employment (at admission):				
Unemployed	70.2%	(40)	71.5%	(88)
Part-time or Occasional	5.3%	(3)	4.9%	(6)
Full-time	10.5%	(6)	7.3%	(9)
Retired or Other	14.0%	(8)	16.3%	(20)
Living Status:				
Alone	44.6%	(25)	47.5%	(58)
With family	32.2%	(18)	32.0%	(39)
Other	23.2%	(13)	20.5%	(25)
Dwelling (at admission to FPI):				
House/Apartment	78.6%	(44)	73.2%	(90)
Hotel	10.7%	(6)	4.9%	(6)
No Fixed Address	7.1%	(4)	12.2%	(15)
Other	3.6%	(2)	9.7%	(12)

The first number indicates the percentage of group total. The number in parenthesis represents the number of subjects.

Table 8

Participants vs. Non-Participants on Psychiatric Diagnoses[a]

Category	Participants		Non-Participants	
Psychotic Disorders*	40.4%	(23)	60.2%	(74)
Non-Psychotic Major Disorders	10.5%	(6)	11.4%	(14)
Non-Psychotic Minor Disorders	35.1%	(20)	32.5%	(40)
Alcohol Use Disorders	28.1%	(16)	22.0%	(27)
Drug Use Disorders**	47.4%	(27)	24.4%	(30)

The first column indicates the percentage of group total. The number in parenthesis represents the number of subjects.

[a]The percentage will not total 100% because an individual may have more than one type of disorder.

* $p < .05$
** $p < .01$

Table 9

Participants vs. Non-Participants on Most Serious Type of Diagnosis

Category	Participants		Non-Participants	
Psychotic Disordered*	40.4%	(23)	60.2%	(74)
Non-Psychotic Major Disordered	8.8%	(5)	10.5%	(13)
Non-Psychotic Minor Disordered	29.8%	(17)	21.1%	(26)
Substance Disordered**	17.5%	(10)	4.1%	(5)
No Diagnosis	3.5%	(2)	4.1%	(5)

The first column indicates the percentage of group total. The number in parenthesis represents the number of subjects.

* $p < .05$
** $p < .01$

Table 10

Comparison of Participants vs. Non-Participants on Comorbid Disorders

Category	Participants		Non-Participants	
No Comorbidity	86.0%	(49)	80.5%	(99)
Psychotic & Drug Use	7.0%	(4)	13.0%	(16)
Psychotic & Alcohol Use	3.5%	(2)	5.7%	(7)
Psychotic & Both Drug and Alcohol Use	3.5%	(2)	0.8%	(1)

The first column indicates the percentage of group total. The number in parenthesis represents the number of subjects.

Table 11

Participants vs. Non-Participants on Most Serious Type of Offence

Category	Participants		Non-Participants	
Violent*	64.9%	(37)	78.9%	(97)
Property*	28.1%	(16)	13.8%	(17)
Miscellaneous	7.0%	(4)	7.3%	(9)

The first column indicates the percentage of group total. The number in parenthesis represents the number of subjects.

* $p < .05$

Comparison of Fit and Unfit Defendants by FIT-R

There were no significant differences found between those individuals that the FIT-R called fit and those it called unfit on demographic variables such as age, education, ethnic group, employment status, or living situation. When the marital status of the individuals was broken down into those who had ever been married (married, divorced, separated, widowed, common-law) and those who had never been married (single) the trend was for more of those who were unfit to have never been married, χ^2 (1, $\underline{N}$ = 57) = 3.64, $\underline{p}$ = .056. When the ethnic groups were collapsed into two groups, White and all other groups, there was a trend for more of the other ethnic groups to be found unfit, Fisher's Exact Test ($\underline{N}$ = 56), $\underline{p}$ = .063.

When the fit and unfit defendants were compared on mental health variables it was found that significantly more of those who had been found unfit were certified under the MHA while on remand at FPI, χ^2 (1, $\underline{N}$ = 57) = 4.43, $\underline{p}$ < .05. Also, the results showed that all of those who were found unfit were on psychiatric medications while remanded, χ^2 (1, $\underline{N}$ = 57) = 4.73, $\underline{p}$ < .05. There were significantly more unfit individuals who had been diagnosed as having psychotic disorders by the SCID, χ^2 (1, N = 57) = 3.87, p < .05, as well as by the psychiatrists, χ^2 (1, $\underline{N}$ = 57) = 4.43, $\underline{p}$ < .05. As well, significantly more of the unfit defendants had been given diagnoses of non-psychotic major mental disorders by the psychiatrists, χ^2 (1, $\underline{N}$ = 57) = 4.88, $\underline{p}$ < .05. Finally, the results show that significantly more of the unfit defendants had diagnoses of psychotic disorders as their most serious diagnosis, χ^2 (4, $\underline{N}$ = 57) = 15.04, $\underline{p}$ < .01.

There were no significant differences between the two groups on their previous contact with mental health professionals, previous hospitalizations, or previous remands for fitness evaluations.

There were no differences found between the fit and unfit defendants on the types of crimes that they committed. As well, there were no differences on any of the other criminological variables such as the presence of a prior criminal record or previous incarcerations.

Chi-square analyses were used to determine how well the diagnoses given by the SCID matched those given by the psychiatrists at FPI. It was found that there was good agreement between the SCID and the psychiatrists for the four major categories of disorders assessed by the SCID: psychotic, χ^2 (1, $\underline{N}$ = 57) = 5.57, $\underline{p}$ < .05; non-psychotic major, χ^2 (1, $\underline{N}$ = 57) = 9.66, $\underline{p}$ < .01; drug use, χ^2 (1, $\underline{N}$ = 57) = 7.39, $\underline{p}$ < .01; alcohol use, χ^2 (1, $\underline{N}$ = 57) = 3.62, $\underline{p}$ = .057. The SCID was not used to assess the non-psychotic minor disorders and therefore no comparison was made for this category.

Comparison of the FIT-R and Institution-Based Decisions of Fitness

The decisions about fitness made by the Fitness Interview Test - Revised were compared to the institution-based decisions about fitness made by the psychiatrists at FPI. There was a high rate of agreement between the decisions made by the FIT-R and those made by the psychiatrists, χ^2 = (1, $\underline{N}$ = 57) = 9.74, $\underline{p}$ < .01. The FIT-R agreed with the psychiatrists' decisions on 49 of 57 cases (47 agreements of fit; 2 agreements of unfit) and disagreed on a total of 8 cases, $\underline{r}$ = .41, $\underline{p}$ < .01. On those cases where there was disagreement, all of them had the FIT-R call the individual unfit and the psychiatrist call the individual fit. As shown in Table 12, the psychiatrists demonstrated 100% agreement on those cases that the FIT-R called fit to stand trial.

The predictive efficiency of the FIT-R decisions of unfitness with respect to the psychiatrists recommendations was as follows: sensitivity (SENS) = 1.00; specificity (SPEC) = .86; positive predictive power (PPP) = .20; negative predictive power (NPP) = 1.00; kappa = .29.

It is important to note that 41 of the 57 participants (71.9%) were on medication during their fitness remand. One reason why the slight discrepancy may exist between the FIT-R and the psychiatrists' decisions may be because the FIT-R and other instruments may have been administered to the participant only shortly after the individual was admitted to FPI and the individual may not have been on medication at the time of participation in the study whereas the individual may have then been administered medications before the fitness assessment was conducted by the psychiatrist.

Table 12

FIT-R versus Psychiatrists' Decisions

Psychiatrists' Decisions

		Fit	Unfit
FIT-R	Fit	47	0
Decisions	Unfit	8	2

When the FIT-R decisions were compared to the court decisions, it was found that there was strong agreement between these decisions, χ^2 (1, $\underline{N}$ = 56) = 4.68, $\underline{p}$ < .05. The FIT-R agreed with the court on 47 of 56 cases (46 agreements of fit; 1 agreement of unfit) and disagreed on 9 cases, $\underline{r}$ = .29, $\underline{p}$ <

.05. All of the disagreements occurred when the FIT-R called the individual unfit and the court called the individual fit.

The predictive efficiency of the FIT-R with respect to court decisions was as follows: sensitivity (SENS) = 1.00; specificity (SPEC) = .84; positive predictive power (PPP) = .10; negative predictive power (NPP) = 1.00; kappa = .15.

Discussion

The comparison of fitness decisions made by the psychiatrists and those made by the FIT-R indicate that the FIT-R has good predictive efficiency and has excellent utility as a screening device. As mentioned in the introduction, it is important that a screening assessment not make false negative errors (i.e., not call someone fit who is truly unfit) as these individuals are then sent on to trial. The FIT-R made no false negative errors in this study. Also mentioned in the introduction was that it is expected that screening devices will overestimate the rate of unfitness in the sample, that is, make a number of false positive errors as these individuals are then sent on for lengthier evaluations of fitness. The FIT-R judged 17.5% (10 of 57) of the sample to be possibly unfit compared to the psychiatrists' rate of 3.5% (2 of 57). This means that there was a 14.0% false positive error rate with 8 of 57 defendants being incorrectly identified by the FIT-R. This indicates that the FIT-R correctly identified 86.0% (49 of 57) defendants as either fit or unfit based on the assumption that the psychiatrist's decision is the "correct" one. If we think about this in practical terms this means that if the FIT-R were to be used as a screening device, only 10 individuals would have been remanded for an inpatient fitness evaluation instead of the 57 that were remanded. Forty-seven of these individuals would have been screened out at some preliminary stage and would not have been detained for any amount of time. This is very important when one considers the amount of time and money

that would be saved as well as the fact that these individuals would not have had their liberty taken away for any length of time.

There are a number of reasons that explain the small discrepancy that occurred between the decisions of the FIT-R and those of the psychiatrists. First, the assessments occurred at different times and may have been affected by medications that were administered to the participants after the FIT-R assessment. The researchers contacted the participants within a few days of their admissions to FPI whereas it appeared that the psychiatrists did not conduct their fitness evaluations until the remands had been at FPI for some time and were somewhat stabilized. It is quite probable that the researchers were conducting the interviews and administering the testing instruments at a time when the participants had not yet been placed on any necessary medications or the medications had not taken effect. Therefore, it is understandable why the FIT-R may have found someone to be unfit who was later determined to be fit by the psychiatrist. Second, the instruments administered as part of this study (FIT-R and SCID) were completed by the participants on different days. The participants were seen in segments of up to two hours at a time and it would often take two or three occasions to complete the interview and instruments. For many forensic remands it is common to have fluctuations in mental state from day to day. As the FIT-R and the SCID were often administered on different days with the FIT-R always being administered first, it is possible that the individual's mental state may have changed from the

time he was administered the FIT-R to the time that he was administered the SCID. The FIT-R and the SCID were usually administered on consecutive days, however, there may have been up to a four day interval for some participants. This allows adequate time for fluctuations in mental state that could have impacted upon the determination of fitness. Third, in this study the FIT-R and the SCID were used together to make determinations of fitness whereas the psychiatrists used their clinical judgment on the legal abilities as well as the presence of a mental disorder. A potential problem exists here as the SCID and the psychiatrist may not agree on the diagnosis or even the type of disorder and therefore this may affect the decisions about fitness. For example, there was one particular case where the psychiatrist gave a diagnosis of Brief Reactive Psychosis at the time of the offence and indicated that there was no current disorder but decided the individual to be unfit to stand trial. This individual was not a participant; however, had he been he would not have been found unfit because he did not have a current mental disorder which is the criteria used in the Code as well as by the FIT-R. Upon examination of the reports to court written by the psychiatrists it appeared that sometimes the psychiatrists would use mental state at the time of the offence in the determination of fitness.

In order to gain a better understanding of the discrepancies that occurred, the reports for those individuals who had discrepant decisions between the FIT-R and the psychiatrist were examined in detail. From this it was determined that all eight individuals were on medication while remanded. Statements were

extracted from these reports that may help to clarify the situation and confirm those suggestions as to why these discrepancies occurred. For example, in one report it was written, "once started on regular medication his mental state and behaviour quickly improved and by the time he was last seen on June 24, 1995, I did not find any evidence of marked psychotic features." As well, "with time and treatment he is now fit to stand trial and no longer needs in-hospital treatment." In another report it was written, "although he remains certified at the time of his transfer to court, and continues to be under treatment, he did improve to the point where, in the author's opinion, he was fit to stand trial." In another report it was written that "Mr. H. was examined by Dr. Z. on December 24, 1994, and it was her opinion that he...was not fit to stand trial." The report then goes on to indicate that the patient was certified and medicated and that "on the basis of my examination on June 5, 1995, I feel that Mr. H. is fit to stand trial and instruct counsel." In yet another report the psychiatrist wrote "there has not been sufficient time for treatment to bring about a change in Mr. H.'s mental state, but I would anticipate that this would be possible within the coming weeks." Then another report was written by the same psychiatrist 18 days later indicating that the individual was now fit to stand trial.

As can be seen by the above discussion, the psychiatrists appear to be trying to restore remanded individuals to fitness before they are returned to court on the initial fitness remand. This may explain the high rate of certification and medication of individuals while they are on remand status. This also helps to

shed some light on the discrepancies that occurred between the FIT-R and the psychiatrists' determinations of fitness. If it would have been possible to have had both fitness assessments completed on the same day there may have been a higher rate of agreement of unfitness. As it stands, however, the FIT-R has strong agreement with the psychiatrists on determinations of fitness and appears to be an excellent screening instrument.

The differences that were found between the participants and the non-participants in Study 2 suggest that the sample of individuals who participated in the study was not representative of the population of remands referred to FPI for assessment. In comparison to the non-participants, the participants were more likely to have been found fit by the court as well as the psychiatrist, were less likely to have been diagnosed with a psychotic disorder, and were less likely to have been certified under the MHA. It is possible that these participants were functioning at a higher level than were the non-participants and therefore, we would expect that there be a lower rate of "unfitness" in this sample simply because of the sampling differences. In order to take part in this study, the remands had to be able to give informed consent to the researchers. In many cases this was not possible as the individual's mental disorder prevented him from understanding that this research was separate from the evaluations conducted by FPI staff, and from the legal proceedings in which the individual was involved. One could make the argument that these individuals were unable to understand the nature or object of the research as well as the possible

consequences of the research and therefore, one would expect that these individuals who could not give informed consent would have a greater possibility of being found unfit to stand trial. This means that there was most likely a higher proportion of "unfit" individuals in the non-participant group and that, conversely, the participant group had a higher proportion of "fit" individuals.

However, in terms of examining the predictive efficiency of the FIT-R, the fact that the study sample may be unrepresentative does not affect the test of whether the FIT-R provides a valid basis for making initial decisions about a remand's fitness. The study sample comprises 57 remands who have both FIT-R results and the decisions by FPI staff, and the focus of the study is on how well the FIT-R predicts the FPI judgments about fitness.

When those individuals called fit by the FIT-R and those called unfit were compared to each other, no significant differences were found between the two groups on any of the demographic variables. This may have been due to the small number of individuals who were found unfit. When the mental health variables were examined, it was found that more of the unfit participants were certified under the MHA, were on psychiatric medications, and had diagnoses of psychotic disorders. As well, the unfit participants were more likely to have had diagnoses of non-psychotic major mental disorders. These differences are the same differences that were found between the fit and unfit defendants for the entire sample of remands in Study 1. These differences appear even though the

majority of the remands were on psychiatric medication and half of the remands were certified under the MHA while on remand status at FPI.

It should also be mentioned that the differences found between the fit and unfit defendants on mental health variables in this study were not only also found in Study 1 but have been found in other studies conducted in Canada. Rogers et al. (1988) compared fit and unfit defendants and found that the "primary diagnosis of the patient was a highly relevant variable in the determination of fitness to stand trial" (p. 197). These researchers concluded that unfit individuals were much more likely to have a primary diagnosis of a psychotic disorder and were much less likely to have diagnoses of drug or alcohol abuse. As well, Hart and Hare (1992) found that diagnoses of psychotic disorders were the best discriminators between fit and unfit defendants.

GENERAL CONCLUSIONS

The results of these two studies suggest that, despite the reforms and changes that were introduced in the 1992 Criminal Code legislation, there are still some problems with the fitness remand process that remain to be addressed. The results of Study 1 indicate that the vast majority of individuals who are remanded for fitness assessments are found fit to stand trial. This raises questions about the appropriateness of many of the referrals for remands. As well, it appears that the implementation of Bill C-30 in 1992 has done little to shorten the amount of time for which an individual is remanded. It would seem that the clause that is included in Section 672.14 of the Code that allows for an individual to be held for 30 days on a fitness remand if both the prosecution and the defence consent is being used more frequently than is the 5 day assessment order as the average length of time that an individual is held on remand is 23 days. It seems that the intention of the law is to have individuals remanded for a short period of time for the sole purpose of assessing their fitness. Nevertheless, the average length of time that individuals are actually remanded for is approximately four times that called for by the law.

It appears as if the fitness remand period is being used for purposes other than assessing fitness. Specifically, it appears that the remand period is being used to provide treatment, usually in the form of psychotropic medication. This appears to be supported by the large number (70%) of individuals who were on psychiatric medications while remanded at FPI as well as the length of time they are held during the remand period. Furthermore, the widespread usage of the certification procedure appears to ensure that these individuals are undergoing treatment, in the form of medication, while at FPI.

The results of Study 1 also indicate that a good first step to screening individuals for unfitness is to determine whether they have a psychotic disorder.

This could be used in conjunction with a legal screening instrument to determine whether or not an individual should be remanded for a lengthier evaluation of fitness. Study 2 focused on the utility of one such legal screening instrument, the FIT-R. This instrument demonstrated perfect sensitivity and negative predictive power. This means that this instrument reliably screens out those individuals for whom there is no question as to their fitness so that they are not detained for lengthy fitness evaluations. This instrument selects a small percentage of individuals for whom fitness is questionable and for whom a more complete fitness assessment should be performed. This is exactly what is expected from a screening device. In this study, only 10 of 57 remands would have been referred to FPI. In other words, decisions about 82% of the individuals would have been made at the initial screening stage, thus avoiding the lengthier inpatient evaluation period. The FIT-R could be administered, along with a mental health screening instrument such as the SCID, to individuals at some preliminary stage and would serve to save valuable resources as it can make a reliable determination of fitness in less that one hour rather than the average 23 day time period that is currently being used.

Directions for Future Research

The results of the present research suggest that much more is being done while an individual is remanded for a fitness assessment than just a fitness assessment. The majority of individuals who are remanded are being treated with psychiatric medications and about half are being certified under the MHA. The psychiatrists are requesting extensions so that treatment in the form of medication may be carried out and the individual may be restored to fitness. It would be interesting to find out why this is occurring. The psychiatrists who are conducting these fitness assessments could be consulted to clarify exactly what procedures are used for determining an individual's fitness. As well, it would be

interesting to determine how the legal statutes with regard to fitness are being interpreted and used by the psychiatrists and others involved in the assessment process.

The present research has indicated that the FIT-R shows promise as a screening instrument but more research is needed. A similar research design with a larger sample, and particularly a larger sample of unfit defendants will be necessary to determine if the predictive efficiency of the FIT-R that was demonstrated in this research holds up.

One of the limitations of the present research was the difference in time between the administration of the FIT-R and the SCID. Future research needs to be conducted that will assess mental state at the same time as the FIT-R is administered. As well, because of the time differences that occurred between the administration of the FIT-R and the psychiatrists' assessments of fitness, future research could also be done that would try to eliminate this time differential. This may be difficult as it will first be necessary to determine how the psychiatrists are conducting their assessments and when they actually make the final decision of fitness.

Finally, other methods of evaluating an individual's mental state could be explored. The SCID offers a very rich source of information about an individual's mental status, however it is quite a lengthy instrument to administer. The SCID was administered in the present research as it assesses information about an individual's past mental health history which is valuable data to have when conducting research. For the purpose of screening those individuals who may have questionable fitness, a shorter instrument such as the Brief Psychiatric Rating Scale (BPRS; Overall & Gorham, 1962) could be used in conjunction with the FIT-R.

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Appendix A

File Data Coding Form

DEMOGRAPHICS

FPI FILE #: _____

SUBJECT #: _____

PARTICIPANT: Y   N

ADMISSION DATE: _____/_____/_____

REPORT DATE: _____/_____/_____

DISCHARGE DATE: _____/_____/_____

LENGTH OF REMAND:_____DAYS   LENGTH EXT. 1:   _____DAYS

                                       LENGTH EXT. 2:   _____DAYS

                                       LENGTH EXT. 3:   _____DAYS

(COPY THE FPI ADMISSION DATA FORM FROM FILE)

CRIMINAL INFORMATION

CURRENT CHARGE(S)	SECTION #	COUNTS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PREVIOUS CRIMINAL HISTORY: Y   N   NM

PREVIOUS TIME IN PRISON: Y   N   NM

PREVIOUS REMANDS FOR FITNESS: Y   N   NM
(make note if for same charge as present)

WERE SECTION 10 RIGHTS READ: Y   N   NM

WAS PATIENT ASKED IF UNDERSTOOD: Y   N   NM

DID PATIENT UNDERSTAND SECTION 10:   Y   N   UNCERTAIN

MEDICAL INFORMATION

PAST

PREVIOUS CONTACT WITH MH SERVICES: Y   N   NM

PREVIOUS HOSPITALIZATIONS: Y   N   NM

PREVIOUSLY ON PSYCHIATRIC MEDICATIONS: Y   N   NM

PRESENT

PSYCHIATRIST: _____

PRESENT DIAGNOSIS: _____
_____
_____

ON PSYCHIATRIC MEDS AT ADMISSION: Y   N   NM

ON PSYCHIATRIC MEDS WHILE DETAINED: Y   N   NM

PSYCHIATRIC MEDS REC. AT DISCHARGE: Y   N   NM

CERTIFIED: Y   N

INCIDENT REPORTS ON FILE: Y   N
     If YES, what type: _____
_____
_____

SUICIDE RISK AT FPI: Y   N   NM

THREATS MADE AT FPI: Y   N   NM

FIT TO STAND TRIAL: Y   N   NM   (FIT but FRAGILE)

If UNFIT, IS HE ABLE TO: 1)   Y   N   NM
                          2)   Y   N   NM
                          3)   Y   N   NM

LIST SPECIFICS OF FITNESS EVALUATION FROM REPORT:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PREVIOUSLY FOUND UNFIT:	Y	N	NM
PREVIOUSLY FOUND NGRI:	Y	N	NM
PREVIOUSLY FOUND NCRMD:	Y	N	NM
PSYCH. TESTS ADMINISTERED: If YES, list:	Y	N	NM

_____
_____
_____
_____
_____

COMPETENT TO PLEAD:	Y	N	NM	
PROPOSED PLEA OF ACCUSED:	G	NG	NCRMD	NM

ADDITIONAL INFO (FITNESS, COMP. TO PLEAD, &/OR CHARTER CAUTIONS)

_____
_____
_____
_____
_____
_____

COURT'S DETERMINATION AS TO FITNESS: FIT   UNFIT

Information for the Department of Justice

FPI File #: _____

Purpose of assessment order: _____ Fitness
                                              _____ Mental Disorder
                                              _____ Infanticide
                                              _____ Disposition for Fitness/Mental Disorder
                                              _____ More than one of the above

Who requested the assessment: _____ Crown
                                              _____ Defence
                                              _____ Judiciary

At what point in the proceedings was the remand requested: _____

What was the duration of the assessment order specified by the court: _____days

        Extension lengths: _____days
                                    _____days
                                    _____days

What was the duration of the actual assessment: _____days

What was the result of the assessment: _____finding UFST
                                              _____finding NCRMD
                                              _____treatment order
                                              _____absolute discharge
                                              _____conditional discharge
                                              _____remand in custody

FPI Coding Sheet - Demographic Information

Date of Birth   ___/___/___

Date of Admission   ___/___/___   Readmission: Y   N

Preferred Language:

Arabic	German	Latvian	Sign
Chinese	Greek	Lithuanian	Slovian
Croatian	Hebrew	Native	Spanish
Czech	Hindi	Philipino	Swedish
Danish	Hindustani	Polish	Ukranian
Dutch	Hungarian	Portugese	Vietnamese
English	Italian	Punjabi	Yugoslav
Finnish	Japanese	Russian	Unknown
French	Korean	Serbian	

Education:

None	Post Sec - Some	Technical/Trade
Elementary	Post Sec - Complete	Vocational
Jr Sec Gr 8-10	Univ - Some	Unknown
Sr Sec Gr 11-12	Univ - Complete	Other

Marital Status:

Single	Divorced	Unknown
Married	Separated	
Widowed	Common-Law	

Religion:

Indian/Inuit	Orthodox	Other Catholic
Judaism	Protestant	Other Religion
Catholic	Other World	None

Birthplace:

NFLD	Sask	Britain
PEI	AB	Europe
NS	BC	Asia
NB	NWT/Yukon	Africa
Quebec	Other NA	Australia/NZ
Ontario	CTRL America	Unknown
Manitoba	S. America	Other

Citizenship:

Native Status	Landed Immigrant
Native Non-Status	Unknown
Canadian	Other

Employment Status:	Self-Employed	Seasonally	Student
	Unemployed	Military	Unknown
	Employed F/T	Retired	Other
	Employed P/T	Homemaker	

Ethnic Group:	Native Indian	Japanese	South European
	French Canadian	East Indian	Arabic
	NA Caucasian	Asian	Latin American
	NA Black	East European	South American
	African	West European	Unknown
	Chinese	North European	Other

Financial Support:	No Income	Employed F/T	Disability Pension
	Welfare	Employed P/T	WCB Benefits
	Family Support	CPP Pension	Handicap Pension
	Savings/Inherit	OAP Pension	Unknown
	UIC Insurance	Company Pension	Other

Source of Income:	No Income	Employed F/T	Disability Pension
	Welfare	Employed P/T	WCB Benefits
	Family Support	CPP Pension	Rehab Program
	Savings/Inherit	OAP Pension	Unknown
	UIC Insurance	Company Pension	Other

Housing Type:	Private Home/Apt	Home Spec Care	Hostel
	Private Room	Home Nurs Care	Correctional Facility
	Priv Board Home	Co-Op Home/Apt	Parole Facility
	Domiciliary Hostel	Group Home	No Fixed Address
	Approved Home	Nursing Home	Riverview Hospital
	Spec Care Res	Home for Aged	Other

Length of Stay:	Less than 1 Week	> 6 Mo < 1 Year
	> 1 Wk < 6 Mo	> 1 Year

Living With:	Alone	Parents	Other Relatives
	Spouse/Common-Law	Friends	Unknown

Appendix B

Coding of the Charges for Each Subject

Subject #	Charges	Code
1	Assault with Weapon Assault Causing Bodily Harm	Violent Violent
2	Theft MV < 1000 Possession Stolen Prop. < 1000 Theft of Gasoline < 1000	Property Property Property
3	Theft < 1000 B/E Mischief - property Failure to Appear Impaired Driving	Property Property Property Misc Misc
4	Assault P. O. Assault	Violent Violent
5	Threatening	Violent
6	Assault Theft > 1000 Failure to stop after accident	Violent Property Misc
7	B/E Confine another Person Assault with Weapon Utter Threats	Property Violent Violent Violent
8	Assault	Violent
9	Assault Theft < 1000	Violent Property
10	Assault Assault by Trespass	Violent Violent
11	Assault B/E	Violent Property

12	Robbery	Violent
	Breach of Probation	Misc
13	Robbery	Violent
	Breach of Probation	Misc
14	Mischief - property	Property
	Mischief	Property
	Damage by Fire	Property
15	Assault	Violent
16	Assault	Violent
17	Assault	Violent
18	Harassment	Violent
	Obstruction of P. O.	Violent
	Failure to Comply	Misc
	Assault	Violent
	Mischief - property	Property
19	Assault P. O.	Violent
	B/E	Property
	Assault Causing Bodily Harm	Violent
	Assault with Weapon	Violent
	Possession of Weapon	Violent
	Mischief - property > 1000	Property
20	Attempt to Murder	Violent
	Assault P. O.	Violent
	Assault with Weapon	Violent
21	Assault	Violent
	Assault P. O.	Violent
22	Utter Threats	Violent
	Disobey Order of Supreme Court	Misc
	Mischief	Property
23	Assault	Violent

24	Failure to Attend	Misc
	Assault	Violent
	Failure to Comply	Misc
	Theft < 1000	Property
25	Careless Handle of Firearm	Violent
	Failure to Comply	Misc
26	Possession of Weapon	Violent
27	Possession of Weapon	Violent
	Nuisance	Misc
28	Theft < 1000	Property
29	Sexual Assault	Violent
30	Assault	Violent
31	Attempted Murder	Violent
	B/E	Property
	Robbery	Violent
32	Assault	Violent
33	Theft > 1000	Property
	Utter Threats	Violent
34	Assault	Violent
35	B/E	Property
	Robbery	Violent
	Unlawful Confinement	Violent
	Assault	Violent
	Assault with Weapon	Violent
36	Sexual Assault	Violent
	Sexual Touching	Violent
37	First Degree Murder	Violent
38	Obstruct P. O.	Violent
	Failure to Wear Seatbelt	Misc
	Failure to Provide Driver's License	Misc
	Utter Threats	Violent

39	B/E with Intent	Property
40	Unlawfully at Large	Misc
	Fraud < 1000	Property
	Fraud > 1000	Property
41	Sexual Assault	Violent
42	B/E with Intent	Property
	Prowl at Night	Misc
	Criminal Harassment	Violent
	Harassing Phone Calls	Violent
43	Loiter in Public Place	Misc
	Assault	Violent
	Extortion	Violent
44	Unlawful Confinement	Violent
	Sexual Assault	Violent
	Possession Dangerous Weapon	Violent
	Assault with Weapon	Violent
	Unlawfully in Dwelling House	Misc
	Forcible Entry	Property
	Failure to Comply	Misc
	Utter a Threat	Violent
45	Possession of Weapon	Violent
	Mischief - property	Property
	Utter Threats	Violent
	Carry Concealed Weapon	Violent
46	Assault with Weapon	Violent
47	Sexual Assault	Violent
	Sexual Interference	Violent
	Invitation to Sexual Touching	Violent
	Sexual Exploitation	Violent
48	Utter a Threat	Violent
	Drive MV while Prohibited	Misc
	Obstruct P. O.	Violent
49	Assault with Intent to Steal	Violent
50	Assault	Violent

51	Assault P.O.	Violent
52	Theft < 1000	Property
	Failure to Appear	Misc
53	Assault	Violent
54	Assault	Violent
	Failure to Attend	Misc
55	Utter Threats to Cause Bodily Harm	Violent
	Possession Dangerous Weapon	Violent
56	Theft < 1000	Property
	Obstruct P.O.	Violent
	Failure to Appear	Misc
57	Assault	Violent
	Violent Confrontation	Violent
58	Possession of Narcotic	Misc
59	Utter a Threat	Violent
60	Assault	Violent
	Failure to Attend	Misc
61	Sexual Assault	Violent
62	Impaired Driving	Misc
	Failure to Comply	Misc
	Possession Narcotic	Misc
63	Dangerous Operation MV	Misc
	Obstruct P.O.	Violent
	Failure to Stop for P.O.	Misc
64	Assault Causing Bodily Harm	Violent
	Mischief - property < 1000	Property
	Assault P.O.	Violent
65	Robbery	Violent
	Failure to Comply	Misc
66	Robbery	Violent

67	Sexual Assault	Violent
68	Causing a Disturbance	Misc
69	B/E with Intent	Property
70	Violated No Contact	Misc
71	At Large on Recognizance	Misc
72	Pointing a Firearm	Violent
	Utter a Threat	Violent
	Use Firearm in Careless Manner	Violent
	Possession Restricted Weapon	Violent
	Unlawfully in Dwelling House	Property
	Possession Dangerous Weapon	Violent
73	Aggravated Assault	Violent
74	Assault with Weapon	Violent
	Assault	Violent
75	Assault	Violent
76	Point Firearm	Violent
	Possession of Weapon	Violent
	Assault while Armed	Violent
	Use Firearm while Committing Offence	Violent
77	Assault	Violent
	Assault Causing Bodily Harm	Violent
	Failure to Comply	Misc
	Robbery	Violent
78	Assault with a Weapon	Violent
	Assault	Violent
79	Possession Stolen Property	Property
	Point Firearm	Violent
	Carry Concealed Weapon	Violent
	Cocaine Possession for Trafficking	Misc
80	Assault	Violent

81	Possession of Weapon	Violent
	Utter Threats	Violent
	Assault P.O.	Violent
82	Aggravated Assault	Violent
83	Theft < 1000	Property
	Assault	Violent
84	Assault Causing Bodily Harm	Violent
85	Obstruct P.O.	Violent
	Assault P.O.	Violent
	Causing a Disturbance	Misc
	Sexual Touching a Minor	Violent
	Invitation to Sexual Touching	Violent
86	Harassment	Violent
87	Theft < 1000	Property
88	Assault	Violent
	Failure to Appear	Misc
89	B/E with Intent	Property
90	Utter threats	Violent
91	B/E with Intent	Property
92	Sexual Interference	Violent
93	Mischief	Property
	B/E	Property
	Failure to Appear	Misc
94	Public Mischief	Property
	Mischief	Property
95	Theft MV > 1000	Property
	Possession Stolen Property	Property
96	B/E to Commit	Property
	Mischief > 1000	Property
	Resist P.O.	Violent
	Mischief < 1000	Property

97	Sexual Touching	Violent
	Sexual Assault	Violent
98	Assault	Violent
	Failure to Comply	Misc
99	Assault Causing Bodily Harm	Violent
	Assault	Violent
100	Theft > 1000	Property
	Failure to Appear	Misc
	Attempt B/E	Property
	Possession Housebreaking Tools	Property
	Possession for Purpose of Trafficking	Misc
101	B/E	Property
	Take MV without Consent	Property
	Take MV with Intent to Drive	Property
	Harassment	Violent
	Theft > 1000	Property
	Possession Stolen Property	Property
102	Mischief < 1000	Property
103	Assault with Weapon	Violent
	Mischief	Property
	Failure to Comply	Misc
104	Mischief - property < 1000	Property
105	Utter Threats to Harm	Violent
	Threatening	Violent
	Mischief < 1000	Property
106	Possession of Weapon	Violent
	Possession of Narcotics	Misc
107	Assault with Weapon	Violent
	Damage by Setting Fire	Property
108	Failure to Have No Contact	Misc
109	Attempt Mischief < 5000	Property
	Damage by Setting Fire	Property
	Utter Threats	Violent

110	Harassment	Violent
	Utter Threats	Violent
	Breach of Probation Order	Misc
	False Statement to P.O.	Misc
111	Prowling	Misc
112	Assault	Violent
	Breach of Bail	Misc
113	Second Degree Murder	Violent
114	Sexual Assault	Violent
	Sexual Touching	Violent
115	Fraud	Property
	Theft > 1000	Property
116	Mischief < 5000	Property
117	Criminal Harassment	Violent
	Assault	Violent
118	Attempted Murder	Violent
119	Utter Threats	Violent
120	Assault Causing Bodily Harm	Violent
	Failure to Comply	Misc
121	Indecent Act	Violent
122	B/E	Property
123	Arson - Disregard for Human Life	Violent
124	Arson - Disregard for Human Life	Violent
	Arson - Disregard for Property	Property
125	Assault P.O.	Violent
126	Breach of Recognizance	Misc
	Harassment	Violent

127	Rape (1979)	Violent
	Indecent Assault	Violent
	Weapon to Commit Rape	Violent
128	Assault	Violent
129	Indecent Exposure	Violent
	Utter Threats	Violent
130	Assault with Weapon	Violent
131	Damage by Fire	Property
132	Mischief - property < 5000	Property
133	Failure to Comply	Misc
	Possession Weapon	Violent
	Breach Probation	Misc
134	Assault P.O.	Violent
	Failure to Report to Probation	Misc
135	First Degree Murder	Violent
136	Assault	Violent
137	Arson - Disregard for Human Life	Violent
	Arson - Disregard for Property	Property
	Attempted Murder	Violent
138	Failure to Comply	Misc
139	Threatening	Violent
140	Assault	Violent
141	B/E	Property
142	Assault Causing Bodily Harm	Violent
143	Sexual Touching	Violent
	Sexual Interference	Violent
144	Assault	Violent
	Assault Causing Bodily Harm	Violent

145	Assault	Violent
146	Assault P.O.	Violent
	Assault	Violent
	Obstruct P.O.	Violent
147	Robbery	Violent
	Assault with Weapon	Violent
	Possession Stolen Property	Property
148	Assault	Violent
	Attempted Murder	Violent
	Sexual Assault with Weapon	Violent
	Sexual Assault	Violent
	Utter Threats	Violent
149	Dangerous Operation MV	Misc
150	Public Mischief	Property
	Mischief	Property
151	Theft MV	Property
152	Theft < 5000	Property
153	Possession of Weapon	Violent
154	Possession of Weapon	Violent
	Assault with Weapon	Violent
155	Mischief - property < 5000	Property
156	Assault	Violent
	Threatening	Violent
	Assault Causing Bodily Harm	Violent
	Failure to Comply	Misc
157	Mischief - property < 5000	Property
158	Utter a Threat	Violent
	Assault with Weapon	Violent
159	Utter a Threat	Violent
	Breach of Probation	Misc
	Breach of Undertaking	Misc

160	Assault	Violent
161	Assault	Violent
	Threatening	Violent
	Failure to Comply	Misc
162	Assault	Violent
	Failure to Comply	Misc
	Failure to Attend	Misc
	Theft < 1000	Property
163	Breach of Probation	Misc
164	Assault Causing Bodily Harm	Violent
	Utter Threats	Violent
165	Resist a P.O.	Violent
	Dangerous Driving	Misc
	Assault	Violent
	Failure to Appear	Misc
	Failure to Attend	Misc
	Theft < 1000	Property
166	Mischief	Property
167	Assault P.O.	Violent
168	B/E with Intent	Property
169	B/E	Property
170	Assault	Violent
171	Assault	Violent
	Assault with a Weapon	Violent
172	Causing a Disturbance	Misc
	Mischief - property	Property
173	Mischief	Property
	Causing a Disturbance	Misc
	Mischief - Motor Vehicle	Property
	Obstruct P.O.	Violent
174	Mischief < 1000	Property

175	Unlawfully in Dwelling House	Misc
176	Assault	Violent
	Utter Threats	Violent
177	Assault	Violent
	Utter Threats	Violent
178	Second Degree Murder	Violent
179	Disobey Order of Supreme Court	Misc
	Breach of Undertaking	Misc
180	Possession of Weapon	Violent
	Use Firearm in Careless Manner	Violent
	Pointing a Rifle	Violent

Appendix C

Coding of Diagnoses for Each Subject

Subject #	Diagnoses	Code[*]
1	Schizophreniform Disorder	P
	Substance Abuse Disorder	D
2	Factitious Disorder	NP-m
	Alcohol Abuse	A
	Cluster A Personality Traits	NP-m
3	Drug Abuse	D
	Alcohol Abuse	A
	Antisocial Personality Traits	NP-m
4	Paranoid Schizophrenia	P
5	Paranoid Schizophrenia	P
6	Bipolar Illness (Manic)	P
	Substance Abuse Disorder	D
7	Cocaine Addiction	D
	Polysubstance Abuse	D
	Alcohol Abuse	A
	Personality Disorder NOS	NP-m
8	Schizophrenia	P
9	Bipolar Mood Disorder - Mania	P
	Alcohol Abuse	A
10	Personality Disorder NOS	NP-m
11	Schizophrenia	P
12	Delusional Disorder - Paranoid	P
	Substance Abuse Disorder	D

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[*] P = psychotic disorder; NP-M = non-psychotic major disorder; NP-m = non-psychotic minor disorder; D = drug use disorder; A = alcohol use disorder.

13	Paranoid Schizophrenia	P
	Substance Abuse Disorder	D
14	No Diagnoses	
15	Schizophrenia	P
16	Adjustment Disorder	NP-m
	Schizoid Traits	NP-m
17	Paranoid Schizophrenia	P
18	No Diagnoses	
19	Substance Abuse Disorder	D
	Antisocial Personality Traits	NP-m
20	Schizoid Personality Disorder	NP-m
	Schizotypal Personality Disorder	NP-m
21	Chronic Paranoid Schizophrenia	P
	Personality Disorder NOS	NP-m
22	Bipolar Disorder - hypomanic	NP-M
23	Schizophrenia	P
	Alcohol Abuse	A
24	Schizophrenia	P
25	Borderline Personality Disorder	NP-m
26	Paranoid Schizophrenia	P
27	Substance Abuse Disorder	D
	Depression	NP-M
	Dependent Traits	NP-m
28	Psychosis NOS	P
	Substance Abuse	D
29	Paraphilia	NP-m
	Histrionic Personality Traits	NP-m

30	Organic Mental Disorder NOS	NP-M
	Polysubstance Abuse	D
	Alcohol Abuse	A
	Organic Personality Disorder	NP-m
31	Substance Abuse Disorder	D
32	Paranoid Schizophrenia	P
	Alcohol Abuse Disorder	A
33	Paranoid Schizophrenia	P
34	Psychosis NOS	P
	Alcohol Abuse	A
	Substance Abuse	D
35	Polysubstance Abuse	D
	Personality Disorder NOS	NP-m
36	Mental Retardation	NP-M
37	No Diagnoses	
38	Delusional Disorder	P
	Schizoid Personality	NP-m
39	Schizophrenia	P
40	Alcohol Abuse	A
	Personality Disorder NOS	NP-m
41	Paranoid Schizophrenia	P
	Substance Abuse	D
	Alcohol Abuse	A
	Marijuana Abuse	D
42	Substance Abuse Disorder	D
	Immature Dependent Traits	NP-m
43	Personality Disorder NOS	NP-m
44	Adjustment Disorder with Depressed Mood	NP-m
	Alcohol Abuse	A

45	Bipolar Mood Disorder	NP-M
	Polysubstance Abuse	D
46	Bipolar Disorder - Mixed	P
	Dependent Personality Traits	NP-m
47	Mild Mental Retardation	NP-M
48	No Diagnoses	
49	Alcohol Abuse	A
50	Schizophrenia	P
51	Paranoid Schizophrenia	P
52	Schizophrenia	P
	Substance Abuse Disorder	D
53	Chronic Schizophrenia	P
54	Schizophrenia	P
55	Adjustment Disorder with Mixed Features	NP-m
	Alcohol Abuse	A
56	No Diagnoses	
57	Adjustment Disorder with Mixed Features	NP-m
	Panic Disorder with Agoraphobia	NP-m
	Alcohol Abuse	A
58	THC Abuse	D
	Alcohol Abuse	A
	Cluster B Traits	NP-m
59	Substance Abuse	D
	Mania NOS	P
	Antisocial Personality Traits	NP-m
60	Substance Abuse	D
	Drug Induced Psychosis	P & D
	Chronic Dysphoria	NP-m
	Personality Disorder NYD	NP-m

61	Mild Mental Retardation	NP-M
62	Paranoid Schizophrenia	P
63	Psychotic Disorder NOS	P
	Personality Disorder NOS	NP-m
64	Paranoid Schizophrenia	P
65	Substance Abuse	D
	Antisocial Personality Disorder	NP-m
66	Schizophrenia	P
	Polysubstance Abuse	D
	Alcohol Abuse	A
	Antisocial Personality Disorder	NP-m
67	Cocaine Abuse Disorder	D
	Cocaine Induced Psychotic Disorder	P & D
68	Post Traumatic Personality Change	NP-m
69	Paranoid Schizophrenia	P
	Substance Abuse	D
70	Bipolar Disorder	NP-M
71	No Diagnoses	
72	Alcohol Abuse	A
	Personality Disorder NOS	NP-m
73	Adjustment Disorder with Depressed Mood	NP-m
	Alcohol Abuse	A
74	Cocaine Abuse	D
	Antisocial Personality Disorder	NP-m
	Borderline Personality Disorder	NP-m
75	Paranoid Schizophrenia	P
76	Alcohol Abuse Disorder	A

77	Substance Abuse Disorder	D
	Adjustment Disorder with Depressed Mood	NP-m
	Antisocial Personality Disorder	NP-m
78	Psychosis	P
79	Cocaine Induced Delusional Disorder	P & D
	Cocaine Abuse Disorder	D
80	Schizophrenia	P
	Mental Retardation	NP-M
81	Paranoid Schizophrenia	P
82	Major Affective Disorder	NP-M
83	Chronic Schizophrenia	P
84	Brief Psychotic Episode	P
85	Bipolar Mood Disorder	NP-M
86	Substance Abuse Disorder	D
87	Substance Abuse Disorder	D
	Cocaine Abuse Disorder	D
88	Schizophrenia	P
89	Paranoid Schizophrenia	P
90	Chronic Paranoid Schizophrenia	P
91	Amphetamine Hallucinosis	P & D
	Polysubstance Abuse	D
92	Substance Abuse Disorder	D
	Paranoid Schizophrenia	P
93	Schizophrenia	P
94	Substance Abuse	D
	Personality Disorder with Antisocial Traits	NP-m

95	Substance Abuse	D
	Transsexualism	NP-m
	Personality Disorder NOS	NP-m
96	Chronic Paranoid Schizophrenia	P
97	Paranoid Schizophrenia	P
98	Adjustment Disorder with Mixed Emotions	NP-m
	Personality Disorder NOS	NP-m
99	Chronic Paranoid Schizophrenia	P
	Passive Aggressive Personality	NP-m
100	Substance Abuse Disorder	D
	Borderline Traits	NP-m
101	Schizophrenia	P
102	Bipolar Mood Disorder - psychotic	P
103	Adjustment Disorder with Mixed Emotions	NP-m
	Polysubstance Abuse	D
	Alcohol Abuse	A
	Personality Disorder NOS	NP-m
104	Paranoid Schizophrenia	P
105	Schizophrenia	P
	Substance Abuse	D
	Schizoid Personality Traits	NP-m
106	Alcohol Abuse	A
	THC Abuse	D
	Cocaine Abuse	D
	Personality Disorder NOS	NP-m
107	Substance Abuse	D
	Mental Retardation	NP-M
108	Psychosis NOS	P
109	Polysubstance Abuse	D
	Cluster B Personality Traits	NP-m

110	Bipolar Disorder - Manic	P
	Delusional Disorder	P
111	Bipolar Affective Disorder - Psychotic	P
112	Adjustment Disorder	NP-m
113	Somatoform Disorder	NP-m
	Personality Disorder NOS	NP-m
114	Pedophilia	NP-m
	Marijuana Abuse	D
115	Delusional Disorder - Paranoid	P
116	Paranoid Schizophrenia	P
117	Delusional Disorder - Erotomanic	P
	Alcohol Abuse Disorder	A
118	Schizophreniform Disorder	P
	THC Abuse	D
119	Alcohol Abuse Disorder	A
	Paranoid Schizophrenia	P
120	Alcohol Abuse Disorder	A
	Marijuana Abuse Disorder	D
121	Paranoid Schizophrenia	P
122	Psychotic Disorder NOS	P
	Alcohol Abuse	A
123	Adjustment Disorder	NP-m
	Alcohol Abuse	A
124	Bipolar Affective Disorder - Mixed	P
125	Substance Induced Psychotic Disorder	P & D
	Alcohol Abuse	A
	Amphetamine Abuse	D
	THC Abuse	D
126	Alcohol Abuse	A

127	Organic Brain Syndrome	NP-M
128	Schizophrenia	P
129	Major Depressive Disorder Alcohol Abuse	NP-M A
130	Psychotic Disorder NOS Alcohol Abuse	P A
131	Alcohol Abuse Disorder Mild Mental Retardation	A NP-M
132	Generalized Anxiety Disorder Mental Retardation	NP-m NP-M
133	Psychosis NOS Substance Abuse Personality Disorder NOS	P D NP-m
134	Bipolar I Disorder - Mixed	P
135	Polysubstance Abuse Adjustment Disorder with Mixed Emotions	D NP-m
136	Manic Disorder	P
137	Chronic Paranoid Schizophrenia Personality Disorder NOS	P NP-m
138	Alcohol Abuse Disorder Dementia NOS	A NP-M
139	Polysubstance Abuse	D
140	Major Depressive Episode with Psychotic	P
141	Schizophrenia Polysubstance Abuse Schizoid Personality Disorder	P D NP-m
142	Schizophrenia Polysubstance Abuse	P D

143	Organic Amnestic Disorder	NP-M
	Organic Personality Disorder	NP-m
	Alcohol Abuse	A
144	Marijuana Abuse Disorder	D
145	Alcohol Abuse Disorder	A
146	Alcohol Abuse Disorder	A
	Borderline Personality Disorder	NP-m
147	Marijuana Abuse	D
	Cocaine Abuse	D
	Alcohol Abuse	A
	Borderline Personality Disorder	NP-m
148	Alcohol Abuse Disorder	A
	Cocaine Abuse Disorder	D
	Antisocial Personality Disorder	NP-m
149	Bipolar Affective - Manic	P
150	Psychotic Disorder NOS	P
151	Major Depressive Episode	NP-M
152	Psychotic Disorder NOS	P
153	Schizophrenia	P
154	Bipolar Disorder I - Manic	P
155	Schizophrenia	P
156	Alcohol Dependence Disorder	A
	Antisocial Personality Disorder	NP-m
157	Psychotic Disorder NOS	P
	Personality Disorder NOS	NP-m
158	Adjustment Disorder with Depressed Mood	NP-m
	Alcohol Abuse	A

159	Adjustment Disorder with Depressed Mood	NP-m
	Alcohol Abuse	A
	Drug Abuse	D
160	Paranoid Psychosis	P
161	No Diagnoses	
162	Chronic Schizophrenia	P
163	Schizophrenic Illness	P
164	Drug Abuse Disorder	D
	Alcohol Abuse Disorder	A
165	Hypomanic Disorder	NP-M
166	Schizophrenia	P
167	Psychotic Disorder NOS	P
168	Severe Mixed Personality Disorder	NP-m
	Polysubstance Abuse	D
169	Psychosis NOS	P
	Substance Abuse	D
170	Bipolar Mood Disorder - Manic	P
	Alcohol Abuse	A
171	Alcohol Abuse	A
	Alcohol Dependence	A
	Mixed Personality Disorder	NP-m
172	Personality Change due to Medical Condition	NP-m
	Narcissistic and Antisocial Traits	NP-m
173	Schizoaffective Disorder	P
	Personality Disorder NOS	NP-m
174	Psychotic Disorder NOS	P
175	Psychotic Disorder NOS	P

176	Conduct Disorder	NP-m
	Substance Abuse	D
177	Amphetamine Abuse Disorder	D
	Amphetamine Induced Psychotic Episode	P & D
	Antisocial Personality Disorder	NP-m
178	Psychotic Disorder NOS	P
179	Schizoaffective Disorder - Bipolar Type	P
180	Alcohol Dependence - Severe	A
	Alcohol Abuse - Severe	A

Appendix D

Coding for Court Decision for Each Subject

Subject #	FPI Decision	Outcome*	Coded Court Decision
1	Fit	NCRMD; INVOL	Fit
2	Fit	-	Fit
3	Fit	-	Fit
4	Fit	-	Fit
5	Fit	-	Fit
6	Fit but Fragile	NCRMD	Fit
7	Fit	-	Fit
8	Fit	-	Fit
9	No Report	Stay	Not Coded
10	Fit	-	Fit
11	Unfit	UNFIT	Unfit
12	Fit	Re-remand	Unfit
13	Unfit	UNFIT	Unfit
14	Fit	-	Fit
15	Fit	INVOL	Fit
16	Fit	INVOL	Fit
17	Fit	NCRMD	Fit

* NCRMD = defendant found not criminally responsible on account of mental disorder; INVOL = individual was admitted to FPI on involuntary status and has to be certified to be treated; UNFIT = individual was admitted to FPI as unfit to stand trial after having been to court; Stay = individual's charges were stayed and is no longer awaiting court proceedings; Fit = individual has gone to court and been found fit to stand trial; "-" = the individual was not admitted back to FPI.

18	Fit	-	Fit
19	Fit	-	Fit
20	Fit	Re-remand	Unfit
21	Fit	NCRMD	Fit
22	Fit	-	Fit
23	Fit	-	Fit
24	Fit	-	Fit
25	Fit	-	Fit
26	Fit	NCRMD	Fit
27	Fit	-	Fit
28	Fit	-	Fit
29	Fit	-	Fit
30	Fit	NCRMD	Fit
31	Fit	-	Fit
32	Fit	-	Fit
33	Unfit	Stay	Unfit
34	Fit	-	Fit
35	Fit	-	Fit
36	Unfit	UNFIT	Unfit
37	Fit	-	Fit
38	Fit	INVOL	Fit
39	Fit	-	Fit
40	Fit	-	Fit

41	Fit	-	Fit
42	Fit	-	Fit
43	Fit	-	Fit
44	Fit	-	Fit
45	Fit	-	Fit
46	Fit	-	Fit
47	Fit	-	Fit
48	Fit	-	Fit
49	Fit	-	Fit
50	Fit but Fragile	INVOL	Fit
51	Fit	-	Fit
52	Fit	-	Fit
53	Unfit	UNFIT	Unfit
54	Fit	INVOL	Fit
55	Fit	-	Fit
56	Unable to Assess	Stay	Unfit
57	Fit	-	Fit
58	Fit	-	Fit
59	Fit	-	Fit
60	Fit	-	Fit
61	Fit	-	Fit
62	Fit	-	Fit
63	Fit	-	Fit

64	Fit	INVOL	Fit
65	Fit	-	Fit
66	Fit	-	Fit
67	Fit	-	Fit
68	Fit	-	Fit
69	Fit	INVOL	Fit
70	Fit	-	Fit
71	Fit	-	Fit
72	Fit	-	Fit
73	Fit	-	Fit
74	Fit	-	Fit
75	Fit	-	Fit
76	Fit	-	Fit
77	Fit	-	Fit
78	Unfit	UNFIT	Unfit
79	Fit	-	Fit
80	Fit	INVOL	Fit
81	Unfit	UNFIT	Unfit
82	Fit	-	Fit
83	Fit	-	Fit
84	Fit	INVOL	Fit
85	Fit	-	Fit
86	No Report	INVOL; Stay	Not Coded

87	Fit	-	Fit
88	Fit	-	Fit
89	Fit	NCRMD	Fit
90	Fit	-	Fit
91	Fit	NCRMD	Fit
92	Fit	NCRMD	Fit
93	Unfit	UNFIT	Unfit
94	Fit	-	Fit
95	Fit	-	Fit
96	Fit	-	Fit
97	Fit	NCRMD	Fit
98	Fit	-	Fit
99	Unfit	UNFIT	Unfit
100	Fit	-	Fit
101	Unfit	UNFIT	Unfit
102	Fit	NCRMD	Fit
103	Fit	-	Fit
104	Unable to Assess	Plead Guilty	Fit
105	Fit	INVOL	Fit
106	Fit	-	Fit
107	Fit	-	Fit
108	Fit	INVOL	Fit
109	Fit	-	Fit

110	Fit	-	Fit
111	Fit	INVOL	Fit
112	Fit	-	Fit
113	Fit	-	Fit
114	Fit	-	Fit
115	Fit	-	Fit
116	Fit	INVOL	Fit
117	Fit	-	Fit
118	Fit	NCRMD	Fit
119	Fit	-	Fit
120	Fit	-	Fit
121	Unfit	UNFIT	Unfit
122	Fit	-	Fit
123	Fit	-	Fit
124	Fit	NCRMD	Fit
125	Fit	-	Fit
126	Fit	-	Fit
127	Fit	UNFIT	Unfit
128	Unable to Assess	Plead Guilty	Fit
129	Fit	-	Fit
130	Fit	NCRMD	Fit
131	Fit	-	Fit
132	Unfit	UNFIT	Unfit

133	Fit but Fragile	-	Fit
134	Fit	NCRMD	Fit
135	Fit	-	Fit
136	Fit	-	Fit
137	Unfit	UNFIT	Unfit
138	Fit	NCRMD	Fit
139	Fit	-	Fit
140	Fit	Re-remanded NCRMD	Fit
141	Fit	-	Fit
142	Fit	-	Fit
143	Unfit	Not yet gone to Court	Not Coded
144	Fit	-	Fit
145	Fit	-	Fit
146	Fit	-	Fit
147	Fit	-	Fit
148	Fit	-	Fit
149	Unfit	NCRMD	Fit
150	Unfit	Stay	Unfit
151	Fit	-	Fit
152	Fit	INVOL; Stay	Fit
153	Fit	INVOL	Fit
154	Fit	-	Fit
155	Fit	NCRMD	Fit

156	Fit	-	Fit
157	Fit	-	Fit
158	Fit	-	Fit
159	Fit	-	Fit
160	Fit	-	Fit
161	Fit	-	Fit
162	Fit	INVOL	Fit
163	Fit	INVOL	Fit
164	Fit	-	Fit
165	Fit	-	Fit
166	Fit	-	Fit
167	Unable to Assess	Plead Guilty	Fit
168	Fit	-	Fit
169	Fit	-	Fit
170	Fit	INVOL	Fit
171	Fit	-	Fit
172	Fit	-	Fit
173	Fit	-	Fit
174	Fit	INVOL	Fit
175	Fit	INVOL	Fit
176	Fit	-	Fit
177	Fit	-	Fit
178	Fit	Not yet gone to court	Not Coded

| 179 | Fit | - | Fit |
| 180 | Fit | - | Fit |

Appendix E

Consent Form

A Study of Participation in the Legal System

INVITATION TO PARTICIPATE: You are invited to participate in a study to learn more about people's abilities to participate in the legal system.

EXPLANATION OF PROCEDURES: If you decide to participate in this study, you will be given a psychological interview that may last up to one hour, a brief measure to look at your verbal and performance abilities, and two measures that ask about participation in the legal system. We will also obtain information from your files here at FPI, including criminal and mental health history and the court recommendations regarding your assessment.

POTENTIAL RISKS AND DISCOMFORTS: There are no physical or emotional risks associated with participating. This research project is separate from the day-to-day operations of the Forensic Psychiatric Institute.

POTENTIAL BENEFITS: There are no direct benefits to you from this research other than the knowledge that you may help us learn more about people's abilities to participate in the legal system. Your decision to participate in the study -- or not to participate in the study -- will have no effect on your stay at the Forensic Psychiatric Institute. You will be paid $5.00 at the completion of the interview.

CONFIDENTIALITY OF DATA: Any information that is obtained during the study will remain confidential to the extent permitted by law. You will not be writing your name or any other identifying information on the research material. Materials will be held in a secure location and will be destroyed upon completion of the study.

WITHDRAWAL FROM THE STUDY: Participation is voluntary. Your decision whether or not to participate will not affect your current or future relationship with the Forensic Psychiatric Institute or with any other branch of the criminal justice or mental health systems.

OFFER TO ANSWER QUESTIONS: If you have any questions, please feel free to ask the interviewers. If you have any questions later you may call the investigators listed on the next page. Thank you for your time and interest.

RESEARCH RESULTS: If you wish to obtain the results of this research, please contact Professor Roesch at Simon Fraser University.

"I have volunteered to participate in this project, which is under the direction of Dr. Ronald Roesch and Dr. J. Ogloff, professors in the Psychology Department at Simon Fraser University. I have been informed of the basic procedures of the study by the researchers, and by reading the first page of this informed consent form. I take part in this study with the understanding that I may withdraw my participation in the experiment at any time, and that I may register any complaint with the primary researcher or with the Chair of the Psychology Department, Dr. Christopher D. Webster."

SIGNATURE OF PARTICIPANT_____ DATE

SIGNATURE OF WITNESS _____ DATE

INVESTIGATORS:

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